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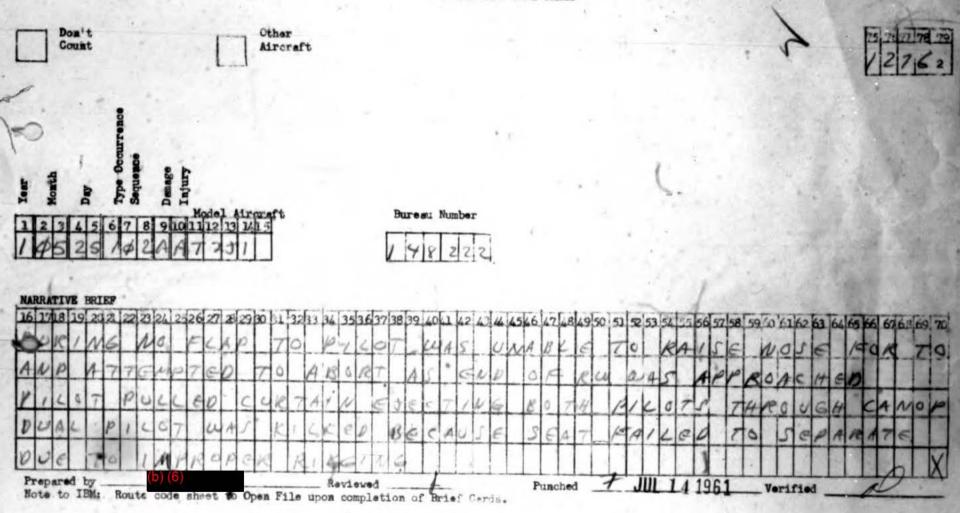


NAVAL AVIATION SAFETY CENTER

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U. S. NAVAL AVIATION SAFETY CENTER U. S. NAVAL AIR STATION NORPOLK 11, VIRGINIA

NASC/113/rop Sers

APR 30 1962

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH FARAGRAPH 70, OPNAV INST 3750.6D

From: Commander, U. S. Naval Aviation Safety Center To: Commanding Officer, Training Squadron SEVEN

Subj: VI-7 AAR ser 6-61 concerning T2J-1 BuNo 148222 accident occurring 25 May 1961, pilot (b) (6)

- The subject report and all endorsements thereon have been reviewed. The Naval Aviation Safety Center concurs with the comments and recommendations of the Aircraft Accident Board as modified by subsequent endorsers.
- 2. The cause of this accident has been recorded by the Center indicating the pilot as the single contributing factor.

(b)(6)

By direction

Copy to: BUWEPS (C-13) 2 copies CNATRA CNABATRA CMC (CODE AAP) BUWEPSREP COLUMBUS CO, NPU EL CENTRO CO VT-4 SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 70, OPNAVINST 3750.6D 27 FEB 1962

FOURTH ENDORSEMENT on TRARON SEVEN AAR ser 6-61, concerning T2J-1, BuNo 148222, accident occurring 25 May 1961, Pilot (b) (6)

From: Chief, Bureau of Naval Weapons

To: Commander, U. S. Naval Aviation Safety Center

Subj: "Aircraft Accident Report; forwarding of

- 1. Forwarded, concurring with paragraph 2. of the second endorsement.
- 2. Anti-suffocation devices for pressure oxygen systems have been and will continue to be investigated. To date, all proposals and developments have jeopardized the system in normal operation.

(b) (6)
(b) (6)

BY direction

Copy to: CNATRA CNABATRA CO, VT-7

Code 05

24 JUL 1961

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 70, OPMAVINST 3750.6D

THIRD ENDORSEMENT on TRANSIS SEVEN AAR ser 6-61, concerning T2J-1, Buno 148222, accident occurring 25 May 1961, Pilot (b) (6)

From: Chief of Naval Air Training

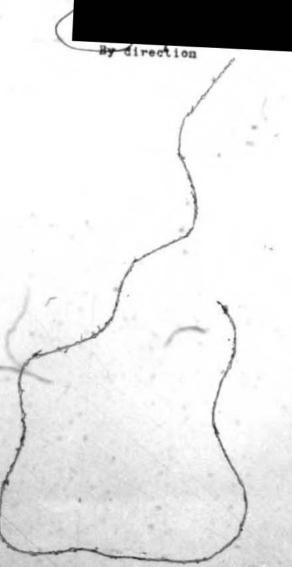
To: Commander, U. S. Maval Aviation Safety Center

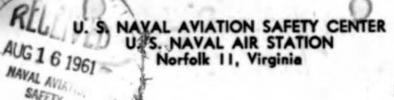
Via: Chief, Bureau of Naval Weapons

Subja Aircraft Accident Report; forwarding of

1. Forwarded, concurring in the comments and recommendations of the Board as modified by the forwarding endorsements. Concur in the action and comments indicated in the forwarding endorsements.

COPY to: CNC (Code AAP) BUWEPEREP Columbus OinC, NFU, El Centro CNULDATRA CO TRARON POUR CO TRARON SEVEN (%)





NASC/531/gh

AVSAF

Commander, U. S. Naval Aviation Safety Center

To:

Clief of Mayal Air Training

Subir

Original AAR Serial 6-61 Concerning

Bureau No. 145725 accident occurring 35 May 19

Pilot

SAFETY CENTER COTTIE

Ref: (a) OPNAVINST 3750.6D

1. The subject AAR was forwarded to your command on 2 Jan 1 Wief of Haval Mir Robic Training.

- 2. Request status of your endorsement and original AAR.
- Your attention is invited to Para 4bd(2) of Reference (a).

By direction

Code 05 14 August 1961

FIRST ENDORSEMENT

From: Chief of Naval Air Training

Commander, U. S. Maval Aviation Safety Center To:

Subj: VT-7 AAR Serial 6-61

Encl: (1) Copy of CNATRA's THIRD ENDORSEMENT on subject AAR of 24 July 1961

1. Subject AAR was endorsed 24 July 1961 and mailed to the Chief, Bureau of Naval Weapons . MAVAVSAFCEN was inadvertently omitted from the copy to addees. A copy of CMATRA's endorsement is forwarded as enclosure (1).

By direction

Code 05 2 9 JUN 1961

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 70 OF OPNAV INSTRUCTION 3750.6D

SECOND ENDORSEMENT on TRARON SEVEN AAR 6-61, concerning T2J-1, BuNo 148222, occurring 25 May 1961, Pilot (b) (6)

From: Chief of Naval Air Basic Training

To: Commander, U. S. Naval Aviation Safety Center

Via: (1) Chief of Naval Air Training (2) Chief, Bureau of Naval Weapons

Subj: Aircraft Accident Report; forwarding of

- 1. Readdressed and forwarded, concurring in the comments and recommendations of the Aircraft Accident Board as modified by paragraph 2 of the First Endorsement.
- 2. In regards to the AAR Board recommendation #2, the Handbook of Inspection Requirements is not designed to enumerate each item to be inspected during an intermediate or major inspection but rather to call attention to areas that require work. Details concerning required inspections should be obtained by reference to applicable sections of the Handbook of Maintenance Instructions. In areas where the HMI is not considered detailed enough to satisfy command requirements inspection procedures should be further amplified by the dissemination of Continuing Action Maintenance Instructions.
- 3. 7 It is recommended that the Bureau of Naval Weapons take action on AAR Board recommendation #4.
- 4. The pilot in this accident violated several squadron standard operating procedures as well as one OPNAV Instruction. Squadron SOPs have little value if they are not rigidly adhered to by all personnel. This is especially true in the Training Command where student pilots are developing flying procedures which will remain with them throughout their career.
- 5. The Commanding Officer, TRARON SEVEN is requested to make sufficient spot checks to insure that standard operating procedures are being adhered to by personnel in TRARON SEVEN.

Copy to:
BUWEPS (C-13) (Direct)
COMNAVAVSAFCEN (Direct)
BUWEPS REP, Columbus
CMC (Code AAP)
OinC, NPU
CO, TRARON FOUR
CO, TRARON SEVEN (2)

C X Swefillt

ORIGINAL

23 JUN 1

FIRST ENDORSEMENT on VT-7 AAR Ser 6-61, Concerning T2J-1, BUNO 118222

From: Commanding Officer, Training Squadron SEVEN, Naval Auxiliary Air Station, Kingsville, Texas

2 3 JUN 1961

Tos

Commander, Naval Aviation Safety Center (1) Chief of Naval Air Basic Training

(2) Chief of Naval Air Training

Subj: VT-7 AAR Ser 6-61; forwarding of

Encl: (10) Addendum to Maintenance Officer's Statement

- 1. Forwarded, concurring with the recommendations of the board.
- 2. It is considered that the primary contributing cause of this accident is pilot factor rather than the suspected failure or malfunction of the elevator control system. There is no concrete evidence to support the latter contention. The pilot's non compliance with standard operating procedures and aviation common sense bred uncertainty, doubt and indecision during one of the most critical parts of the flight take off. As a result, the pilot was incapable of making a quick analysis of the situation and taking the sound action necessary to handle the airplane.
- 3. The Maintenance Officer's statement did not comment on either the ejection seat or the gas line to the canopy actuator. Enclosure (10) to this endorsement is an addendum to the Maintenance Officer's statement and corrects this deficiency.
- 4. Enclosure (2) contains a resume of the pilot's flying experience. He had not had any accidents in his previous flying career.
- 5. The importance of using check lists and of adhering to standard operating procedures has been pointed out again to all pilots. To ignore such good practices is to invite the same kind of confusion and doubt as commended during this accident.
- 6. To combat ejection seat maintenance errors the recommendations of the board will be implemented. Further, the proposals outlined in the "Weekly Summary of Aircraft Accidents" (8-11 May) will be adopted.

R. F. RE

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 70 OPNAVINST 3750.6D

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PART V THE ACCIDENT

ORIGINAL

On 25 May 1961, CAPT (b) (6) signed out for T2J-1, bureau number 148222 with ICDR SECKINGER as dual pilot for a ferry flight from NAAS KINGSVILLE, TEXAS to NAS PENSACOLA, FLORIDA.

The aircraft was pre-flighted by both pilots and no discrepancies were noted. The pilots strapped in with CAPT (b) (6) in the front cockpit and LCIR SECKINGER in the rear cockpit.

CAPT (b) (6) went over the pre-start check-off list and started the aircraft. The start was normal and CAPT (b) (6) went over his pre-taxi check-off list. He noted that the speed brakes did not extend when he pressed the switch to extend the speed brakes. The speed brakes indicator would show barber pole as he pressed the switch and then would immediately show in when he let go of the switch. A communications check on the intercommunications system was made and it worked normal. The oxygen masks were not fully put on by either pilot.

CAPT (b) (6) then taxied out to the duty runway completing his pre-take-off check-off list while taxiing except for the canopy and his shoulder harness.

CAPT (b) (6) requested and received clearance for take-off. As he taxifed into position for take-off, he closed the canopy and locked his shoulder harness and put the flaps up for a flaps up take-off.

CAPT (b) (6) applied full throttle control while holding his brakes and as soon as the engine tachometer indicated 100% RPM, CAPT (b) (6) released the brakes and started the take-off roll.

CAPT (b) (6) noted the oil pressure was low (estimate 70 LBS pressure) and tried to tell LCDR SECKINGER in the rear cockpit about it. He held his oxygen mask over his face with his left hand as he pushed the intercom switch to "CALL" but was unable to get a response from LCDR SECKINGER. The other instruments indicated the engine was operating normally.

LCDR SECKINGER spoke on the intercom shortly after this, but CAPT (b) (6) did not understand what was said.

The take-off roll continued until 100 kts was reached and CAPT (b) (6) tried to raise the nose to take-off attitude. The nose would not come up even though an airspeed of 110 to 115 kts had been attained. CAPT (b) (6) tried a second time to raise the nose to take-off attitude, but to no avail.

When the nose did not come up on this second attempt, CAPT(b) (6) decided to abort the take-off. He reduced power to idle, turned off some switches and reached for the hook, but he saw he was past the runway arresting gear. He pulled the stick full back and applied full brake and saw he couldn't stop the aircraft before going off the end of the runway.

Inasmuch as there was no runway over-run, CAPT pulled the ejection curtain at the end of the runway. The ejection control was in the front cockpit and both pilots were ejected through the canopy.

CAPT (b) (6) section of the ejection system worked as it was designed to do, with the exception of the canopy. The distance from point of initiation to touchdown was 624 feet. LCDR SECKINGER went 599 feet from the end of the runway in the seat. Seat separation did not occur due to the fact that the striker pivot clevis pin in the aneroid linkage was missing.

The aircraft rolled off the end of the runway into a deep gully and came to rest 491 feet from the end of the runway. The aircraft caught fire immediately. The crash crew arrived on the scene shortly thereafter and took charge.

PART VI DAMAGE TO THE AIRCRAFT

The aircraft was completely destroyed by the fire after it went into the gully.

It is estimated that the aircraft was moving at about 70 kts or more as it approached the embankment of the gully. The right main landing gear was collapsed on a concrete drainage block at the edge of the embankment.

The aircraft went over the embankment and the right wing and nose hit the other side of the gully, which ran at about a 20° angle to the aircraft's path over the ground. The aircraft slid for approximately 80 feet as it caught fire and burned.

The extensive damage to the aircraft was due to its inaccessibility to fire fighting equipment. (see enclosure 6A and 6C.).

PART VII THE INVESTIGATION

During the investigation, the following facts were established:

Pre-Flights

- a. A proper pre-flight of the aircraft was conducted by both pilots and no discrepancies were noted.
- b. The pre-taxi check-off list was performed while taxiing out, Which is contrary to squadron S.O.P. It was noted by CAPT (b)(6) that the speed brakes would not extend. The speed brake indicator showed "barber pole" when the speed brake switch was pushed to and when the switch was released, the speed brake indicator would immediately indicate IN. The hydraulic pressure indicator showed 3000 lbs pressure.
- c. The intercommunications system was checked by the pilots and worked normally.
- d. The pre-take-off check-off list was performed while taxiing out to the duty runway. This practice is also contrary to squadron S.G.P.

- e. The aircraft was taxied into position for take-off, while the canopy was being closed and while CAPT (b) (c) locked his shoulder harness. Both
 of these items are on the pre-take-off check list and should have been
 completed prior to taking the runway.
- f. The oxygen masks were not put on and the intercom switches were on cold mike. (Contrary to OPNAV Instruction & Squadron S.O.P.)
- g. CAPT (b) (6) raised the flaps for a flaps up take-off. Contrary to Squadron S.O.P.

2. Take-Off Roll

- a. Power was applied to 100% RPM and as soon as it was reached, the take-off roll was started. Squadron S.O.P. requires a complete check of engine instruments prior to releasing the brakes for take-off roll. The engine instruments were not checked prior to starting the take-off roll. CAPT (5) (6) noted the oil pressure was low, however all other instruments were normal on the roll.
- b. CAPT (b) (6) tried to contact LCDR SECKINGER on the intercom to tell him about the low oil pressure, but was unable to contact him.
- c. At 100 kts, CAPT (b) (6) tried to raise the nose of the aircraft to take-off attitude. The nose did not come up and even though an estimated speed of 110 to 115 kts had been attained.
- d. CAPT (b) (6) decided to abort; cut power to idle turned some switches off, applied brakes and reached for the hook handle. The aircraft had already passed the runway arresting gear when the pilot reached for the hook handle. The arresting gear is 1500 feet from the upwind end of a 6,000 foot long runway.
- o. CAPT (b) (6) couldn't stop so he pulled the stick all the way back for more braking action and reached for the gear handle thinking he could stop the aircraft with the gear up in the overrun. On the last 800 feet of the runway there were light traces of rubber from the main gear tires.
- f. CAPT (b) (6) then realised there was no overrun and initiated ejection at the end of the runway. Ejection control was in the front cockpit, therefore, CAPT (b) (6) had ejection control for both pilots.
- g. CAPT (b) (6) went through the air head first after seat separation and did not feel the shock of the parachute opening.
- h. CAPT (b) (6) hit a boundary fence and small branches before he landed on the ground 62h feet from the end of the runway.
- i. LCDR SECKINGER did not separate from his seat and he came to rost in the seat 599 feet from the end of the runway.

3. Ejection system.

- a. Rear seat S/N.H-407
 - (1) Neither face curtain initiator (T-30E1) fired.
 - (2) Neither face curtain cable cutter fired.
 - (3) Harness release gun was not fired.
 - (4) Neither the seat bottom bladder nor its initiator (T31E1) inflated or fired.
 - (5) Neither back bladder nor its initiator T-31El) inflated or fired.
 - (6) The "D" ring handle was pulled and the 2 (T-30El) initiators were fired.
 - (7) The seat drogue gun was fired.
 - (8) The ameroid unit Arming pin was not pulled.
 - (9) Evidence strongly supports the fact that no pivot pin was in the striker bellcrank at the time of ejection. (See enclosures 6H and 6I) Striker bellcrank engagement with the striker pin on the seat bulkhead produced sufficient rotation to pull firing pin from drogue gun, but the stroke was not sufficient to pull the aneroid atming pin.
- b. Front seat S/N H-406
 - (1) Both face curtain initiators (T 30E1) were fired.
 - (2) Both face curtain cable cutters fired and the wire lines on the face curtain were properly cut.
 - (3) The "D" ring handle was actuated and both (T-30El) initiators were fired.
 - (4) The drogue gun was fired.
 - (5) The ameroid unit fuctioned properly.
 - (6) The harness release gun fired rotating the harness release bellcranks the required distance to release the two lap belt release pins and the shoulder harness pin.
 - (7) Both back and seat bottom bladders and their respective (T-31E1) initiators actuated properly.

(3) This total seat system functioned as required.

c. Canopy

- (1) The gas line to canopy actuator shows no evidence of having been attached (see enclosure 6J)
 - (2) There were no signs around the gas inlet port of the canopy actuator that ballistic gas had reached this point.
 - (3) The canopy actuator screw jack was nine threads up from the fully closed position.
 - (4) Ejection was through the canopy.

d. General

- (1) The trajectory to be realized for a speed range between 90 to 110 kts would be as follows:
 - (a) Pilot 500 to 550 feet to point of truchdown.
 - (b) Seat Approximately 400 450 feet.
- (2) Review of trajectory and distance measured in relation to CAPT (5)(6) shows the trajectory to be as designed.
- (3) Due to separation not occurring on the rear seat, the trajectory would be longer due to the seat-man combination weight, which would result in a slower deceleration and therefore longer horizontal distance travel.

4. Elevator Control System:

- a. The elevator control cables from the boost actuator in the tail to the sheave aft of the elevator control linkage were intact.
- b. The elevator control linkage from this station forward was destroyed by the intense fire.
- c. The elevator boost actuator is being sent to 0 & R, Pensacola, Florida to determine if it malfunctioned.
- d. The elevator trim actuator on the port side was recovered and was found in the neutral position which is correct for take-off.
- e. The starboard trim actuator was not recovered.
- f. There was boost hydraulic pressure available to the system as shown by the indicator.
- 5. Engine and involved component parts.

- a. All the engine bearings had oil in them and showed no sign of undue wear.
- b. The oil pump was in the gear train and no shafts were sheared so it is assumed the oil pump was working correctly.
 - c. The engine was seized due to impact damage to the gear train and the compressor shroud.
 - d. The oil pressure guage indicated low oil pressure probably because of instrument malfunction and not actual low oil pressure.
- 6. Speed brakes.
 - a. The speed brakes were IN and locked when recovered from the wreckage.
 - b. Due to the extensive fire damage the cause for the speed brakes not extending could not be determined.
- 7. Take-off computations and tests conducted.
 - a. The pilot's handbook does not contain take-off charts for flaps up, therefore, the take-off distance and lift off speed were obtained from the Field Engineering Trainer Group, North American Aviation Inc., Columbus, Ohio.
 - (1) The given conditions were the same as at the time of the accident:
 - (a) Runway temperature 840.
 - (b) Seven knot head wind.
 - (c) Gross weight 11,600 lbs.
 - (d) 52 feet above soa level
 - (e) Flaps up.
 - (2) The lift off speed was determined as 110-125 kts and the take-off distance as 3000 feet maximum.
 - (3) The lift off speed and take-off distance for the above conditions, but with flaps down is 98 kts and 2300 feet. Taken from charts in Pilots Handbook.
 - b. A take-off test was conducted.
 - (1) The following given conditions were used:
 - (a) Rumay temperature 84.60

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- (b) 10 15 kts headwind
- (c) Gross weight 11,600 lbs.
- (d) 60 lbs of baggage in nose of aircraft. (CAPT (b) (6) aircraft had 58 lbs of baggage).
- (e) 52 feet above sea level
- (f) Flaps up.
- (g) Stick was brought back at 100kts.
- (2) The results.
 - (a) Nose of the aircraft came up at 100 kts.
 - (b) Aircraft came off the deck at 115 kts.
 - (c) The take-off roll distance was 2600 feet.
 - (d) No unusual stick feel was encountered.
- 8. Stopping distances (From Pilot's Handbook)
 - a. From 98 kts 1720 feet.
 - b. From 115 kts 2320 feet. (Curves were extended beyond graphed part of chart and interpolated).

PART VIII THE ANALYSIS

 THE TAKE-OFF - In view of the flaps up take-off test conducted and the flaps up take-off information received from the Field Engineering Trainer Group, NAA, Columbus, Ohio, this aircraft should have become airborne when the stick was brought back to the take-off attitude.

The board was unable to determine the cause for the failure of the aircraft to assume a take-off attitude beyond the possibility of a failure or malfunction in the elevator control system. The elevator hydraulic boost actuator is being sent to 0 & R, Pensacola for DIR. The hydraulic lines on this actuator cannot be hooked up backwards due to non-compatible fittings.

The control linkage in the cockpit areas was completely destroyed by the fire. The cause for the failure or malfunction of the elevator control system is therefore undetermined.

- 2. Procedures used.
 - a. The pre-taxi check-off was performed while taxiing out, which was in violation of the squadron's operating procedures.

URIGINAL

- b. The speed brakes not extending is reason enough for the pilot to down the aircraft for the following reasons:
 - The pilot did not know the reason the speed brakes would not extend.
 - (2) The speed brakes not extending could be a possible indication of a failure in the hydraulic system.
- c. The pilot started his roll for take-off without checking all of his engine instruments. The pilot should not have started a take-off roll with the oil pressure guage indicating low oil pressure (70 lbs). Minimum pressure for 100% is 114 lbs. Starting the take-off roll prior to checking all the engine instruments is in violation of the squadron's operating procedures.
- d. The decision of the pilot to make a flaps up take-off on a 6000 foot runway was very unwise and in violation of the squadron's operating procedures. The position at which TAKE-OFF was initiated was approximately 500 feet from the take-off end of the runway, therefore, the runway available for use was 5,500 feet.
 - (1) The take-off distance for flaps up, under the conditions this attempt was made was a maximum of 3000 feet. The minimum stopping distance from 115 kts is 2320 feet. This requires 5320 feet of runway for take-off and abort without hesitation or indecision on the part of the pilot.
 - (2) The take-off distance for flaps down under the conditions this attempt was made require a roll distance of 2300 feet and a lift off speed of 98 kts. The minimum stopping distance from 98 kts is 1720 feet. This requires 4020 feet for take-off and abort. This would leave 1480 feet of spare runway and if the abort had been done without hesitation, the aircraft could have come to a stop in the arresting gear, which is 1500 feet from the end of the runway. It is felt therefore that had a flaps down take-off been attempted, this accident could have been averted.
- e. Neither pilot had his oxygen mask on which is in violation of
 Training Squadron SEVEN Instruction 10127.1B which is quoted in
 part "All personnel will wear the following items of flight clothing
 while flying in the T2J-1 aircraft: f. Oxygen mask from takeoff to landing".

The pilots not having their masks on and being on cold mikes definitely added to the confusion during the take-off, when CAPT (b) (6) was unable to get ICDR SECKINGER's attention by clicking the intercom switch to "CALL" position.

All the above listed violations definitely added to the confusion of the take-off and possibly hindered the pilot from making the correct decision at the right time when the difficulty of not being able to raise the nose was encountered.

- 3. The ejection system.
 - a. The ejection was through the canopy due to the fact that the gas line to the canopy actuator was not attached. This item is on the maintenance major check sheet and was signed off as having been CHECKED on this aircraft during the last check.
 - that the pivot pin in the striker bellcrank was missing at the time of ejection. There is evidence of wear in the striker bellcrank pivot pin hole indicating that the pivot pin had been installed at one time. Since there were no work orders issued requiring removal of this pivot pin, it is believed by the board, that this pin was not properly secured by a cotter pin at the time of installation or it was removed and reinstalled insecurely or not reinstalled at all without a work order being issued. All other seats of this squadron were inspected for missing pivot pins and all pivot pins were found in and properly secured. The maintenance inspection check sheet lists the aneroid area as a check item, but does not spell out the items in this area, one of which is the anchor pin for the striker bellcrank.
 - c. Front seat. Everything in this seat system functioned as designed. It could not be determined as to how the "D" ring was pulled, but the initiators were fired. The pilot states he only pulled the curtain.
 - d. Oxygen masks.
 - a. Neither pilot had his oxygen mask on completely. They were hanging by one Hardiman fitting from the helmet.
 - b. The bailout bottle lasts from 2 to 3 minutes after ejection.

 CAPT (b) (6) was knocked unconscious when he hit the fence and by the time assistance arrived, it is believed he would have suffocated, had he had his mask on correctly. Since ground level ejections can end in rough terrain and the pilot can be injured there is a need for automatic release of the mask or some automatic device to let outside air into the system when the bailout bottle is empty after ejection.

PART IX COMMENTS

The primary contributing cause factor in this accident is the fact that
the aircraft did not become airborne due to a suspected failure or
malfunction of the elevator control system.

- 2. The contributing pilot cause factor in this accident is that a flaps up take-off was attempted, which required almost the full length of the runway for take-off roll and abort stopping distance. This same take-off attempt with flaps down left 1500 feet of runway remaining after take-off roll and abort stopping distance.
- 3. This take-off should never have been attemped for the following reasons:
 - a. Both pilots were Assistant Maintenance Officers and should have realized the significance of taking an aircraft that had discrepancies.
 - b. The low oil pressure would have been noted prior to commencing take-off roll had the correct procedure of checking engine instruments been used.
 - c. The speed brakes not extended
- 4. The procedure of going over check-off lists while taxiing on any type of flight is in violation of standard operating procedures of this squadron.

PART X RECOMMENDATIONS

- 1. It is recommended that closer attention by supervisory authority be exercised both in adherance to Standard Operating procedures and in review of maintenance procedures. A continuous review of procedures by all personnel, flight and traintenance, must be examined periodically in an effort to remain cognizant of changes required or occurrences of non-compliance with standard operating procedures and/or check sheets.
- 2. It is recommended that both the intermediate and major check sheets on the maintenance of the ejection seats be revised so that the check sheet shows each item to be checked, especially the striker arm pivot pin, which is not listed on the check sheet. It is further recommended that no work be accomplished on the ejection system without a work order being issued.
- 3. It is recommended that only qualified personnel be permitted to sign off gripes on/or inspection of the ejection seat system. If the number of qualified personnel assigned do not meet the requirements of the command, then a strenousconsciontious effort must be existed to train enough other personnel to meet the needs. Special attention must be given to selecting only the most highly qualified personnel to be used as instructors.
- 4. It is believed that had CAPT (b) (6) been wearing his oxygen mask at the time of his low level ejection, he would have died from suffication. This belies is based on the figures of usable time/quantity of the bailout bottle, which is activated at ejection. The emergency oxygen supply is capable of providing approximately 2 to 3 minutes of normal breathing at sea level. From the time of initiation of ejection until help arrived for CAPT (b) (6), 5 to 6 minutes has elapsed and CAPT (b) (6) was unconscious from the time he contacted the ground.

V

in view of the above it is recommended that the Bureau of Weapons immediately initiate a study of the problem, which is to insure that outside air be made available to the pilot as soon as the emergency oxygen supply has been depleted.

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STATEMENT of CAPT (b) (6) USMC - PILOT

I signed out for T2J-1, BUNO 148222 about 0730S on 25 May 1961 with ICIR SECKINGER as dual pilot. We both did a complete pre-flight on the aircraft and there were no discrepancies noted. I went over the pre-start check-off list and started the aircraft. The start was normal.

I performed the pre-taxi check-off list while taxiing out and noted my speed brakes would not extend. Mr. SECKINGER and I made an intercom check and it was working normal.

The pre-take-off check list was completed and I put my flaps up for a flaps up take-off. I taxied out for take-off as I closed the canopy and locked my shoulder harness. When I got to 100%, I started rolling immediately.

Mr. SECKINGER and I were on cold mike and did not have our masks on. I noted as I was rolling the oil pressure was low. I noticed light vaporization in the presurization intake and an unusual smell in the cockpit. The cockpit temperature was set on one. I kept clicking the mike trying to get Mr. SECKINGER's attention and he just looked at me in the mirror, not realizing I was trying to get him. The intercom had checked out okay in the line. Right after this, I heard him on the mike, but I did not understand what he said. At 100 kts, I tried to raise the nose to a take-off attitude, but it wouldn't come up. I reached an airspeed of about 110 to 115 knots and the nose still wouldn't come up. I could move the stick back, but it felt unusual. The nose did not assume take-off attitude. I didn't want to take-off, if it was going to be that hard to get off the ground, so I aborted. I took power off to idle and cut some of the switches and put my feet on the brakes, but I did not slow up. Then I reached for the hook and saw that I was past the barrier. Then I pulled back on the stick to get more braking action and I started to lift the gear handle. I thought if I could get the gear up, I could stop it, but there was no over run, so I decided to eject. I ejected right on the end of the runway. I estimate I was going about 60 knots. I had ejection control in the front cockpit. I ejected with the curtain and I believe LCDR SECKINGER went way ahead of me. The next thing I knew, I was going head first above the ground. I did not feel the parachute open. I remember looking back and seeing the risers as I landed on the fence and trees.

This accident could have been prevented if I had aborted the take-off earlier.



SPECIAL HANDLING REQUIRED IN ACCORDANCE

25 Ly 1961

Statement of CAPT. (b) (6) directly following crash as heard by

CAPT (b) (6) stated we taxied out to the runway, I was in the front cockpit. We pulled out on the runway, my speedbrakes were in and my flaps were up. I applied power for take-off and I noticed the oil pressure was low. I started to roll.

LCDR (b) (6) then interrupted with the question. "You took off with your flaps up?".

CAPT (b) (6) answered, "Yes, I wanted to do it the way, I was going to make a left turn out."

CAPT (b) (6) continued his statement. We were going down the runway, plane wasn't going to fly, speed brakes wouldn't work, brakes wouldn't work worth a dawn, can't stop, I ejected.

This statement was heard approximately ten minutes after the crash, at the location where CAPT (b)(6) came down. CAPT (b)(6) regained consciousness at that time; he had not received any sedation, and considering his condition spoke very legibly and distinctly. He did not seem to be in great pain and was completely aware of what had happened.

(b) (6)

ENCLOSURE 1B



COMMAND VMF-115	TIME AND TYPE FLYING AUG SFEB 57 VF	TYPE A/C FLD-1 RLD-6 AD-5 T-28B SNB-5 TV-2	HOURS FLOWN 50 4 3 5 2 27
MARAVNRCPLBN AIRFHFPAC	MAR 57-APR 57 PROFICIENCY	TV-2	2
H & S FMF CAMP LEJUNE	PROFICIENCY	SNB TV-2 F9F-8	11/14 70 111
H & S 8TH MAR 2ND MAR DIV	FEB 59-JUNE 59 PROFICIENCY	SNB-5 F28B	23
VT-7	JULY 59-MAY 61 FLIGHT INSTRUCTOR	T2V-1 T-28B SNB-5 T2J-1) 11/14 221 31/ 331
	(b) (6)	0
		LCDR USN AFETY OFFICER	

ENCLOSURE 2A

RESUME OF LCDR SECKINGER'S FLYING EXPERIENCE

COMMAND	TIME AND TYPE FLYING	TYPE A/C	HOURS FLOWN
VT-94	OCT 44-NOV 45	TBM	1442
CASU-22	DEC 45-MAR 46 PROFICIENCY	TBM SNB	22 10
VHF-3	MAR 46-MAY 46 VR FERRY	TBM RLD	18 36
VR-6	WAY 46-JUNE 47	RSD SNJ	770 25
VF-98 (RESERVE SQU.D) INACTIVE DUTY	JUNE 47-JUNE 48 PROFICIENCY	FLU AD TBM	42 90 45
FASRON-1	JUNE 48-NOV 49 PROFICIENCY	F6F SNB	32 113
INACTIVE DUTY	NOV 49-JAN 51	NO FLYING	
NAS COLUMBUS	J/N 51-MAR 54 VR AND PROFICIENCY	SNJ SNB F6F F4U F2H TV-12 R4D R5D	38 318 115 31 68 37 173 138
NAS SEATTLE	W.R 54-OCT 55 VR AND PROFICIENCY	SNB RSD	142 334
CIC NAS GLENVIEW	NOV 55-FEB 56 TRAINING	SNB	37
TACRON 23	FEB 56-JULY 56 VR AND PROFICIENCY	SNB	75
FLIGHT TRO CEN NORFOLK	JULY 56-APR 58 PROFICIENCY	SNB	173
VP(AN) 4	APR 58-AUG 59	TV-2 F2H SNB	30 113 40
VT-7	SEPT 59-MAY 61 TEST AND PROFICIENCY	SNB T2V (b) (6)	158
	ENCLOSURE :	The state of the s	USN

SPECIAL HANDLING REQUIRED IS ACCORDANCE WITH PARA 70 OPENVISET 3750.6D

STATE ENT OF ENS(b) (6)

USNR - STUDENT PILOT

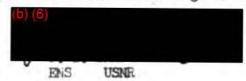
At the time of the accident, I was in the control tower. I had a very clear view of the accident. The aircraft was cleared for take off on rurway 17. It was the first plane to be cleared on rurway 17, since the duty runway had been 13 just prior to the accident.

The winds were from 130-150/8, the alt. 29.86. The aircraft started it's normal take-off roll. ..s I watched the plane gain speed down the runway, I noticed that it was unusually fast for not being airborne.

as the plane passed the arresting gear, I knew something was definetly wrong and since the plane had not even assumed the take-off attitude. I then saw the nose clee compress as the brakes were applied, but much too late to stop the plane.

The two pilots ejected just prior to leaving the runway. The seats did not appear to go higher than 50-75 feet. The plane left the runway and exploded. One of the parachutes streamed, but did not open. The other did not appear to even stream.

I am a flight student in Basic Training. I am in Formation stage of Training.



THIS IS CONSIDERED TO BE A CREDITABLE STATEMENT

STATEMENT OF (6) (6) ACC - CHIEF TOWER OPERATOR

At 11,18Z - VJ1,8222, CREY CAK 177 T2J was cleared for take-off on runway 17 South Field. His take off roll seemed normal, with sufficient airspeed to get airborne, after he passed the arresting gear, it looked as though he was trying to abort his take off. I realized he could not possibly stop in time and that he would drop off the end of the runway, so I yelled for (b) (6) AC1 to ring the crash phone. The A/C went off the end of the runway and burst into flames. I saw one parachute open partially and did not see the other one.

Kingsville 10MB5 was on the hardstand and was on the scene with Kings 17 ambulance at 1149, about one minute later. Kingsville 12MB5 at the base of South Tower was on the scene at 11512. The Helicopter was on the scene at 11522.

The weather at the time was 1400 broken 9000 broken higher broken, vis 10, temperature 84, Dew pt. 74, Wind SSW 7, ALT 29.85, Relative Humidity 73%.

My experience as a tower operator is as follows:

1. 9 yrs. tower

2. 3 yrs. GCA, and have attended Class A, B, and C AC Schools.



THIS IS CONSIDERED TO BE A CREDITABLE STATEMENT

STATEMENT OF (b) (6)

AC1 - TOWER OPERATOR

VJ48222 T2J was taking off on runway 17, and was passing the gear. The aircraft appeared to make an attempt to abort. As the aircraft passed the intersection of taxiway E, the crash phone was activated. Both ejection seats left the aircraft as it passed the roll off end of the runway. The seats appeared to go up about 500 feet. The aircraft went off the roll end of the runway and burst into flame as it went down into the gully. As I looked up from the crash phone, I saw 2 MB5s, an ambulance and crash pickup proceeding down runway 17 to the scene.

Weather at the time of the crash was 1400 broken 9000 broken higher broken, visibility 10, temperature 84, dew point 74, SSW 7, altimeter 29.85, Relative Humidity 73%.

I have the following experience in air traffic control:

- I. 7 years, 9 mo. total experience.
- 2. 1 year, 6 mo, radar controller.
- 3. 6 years, 3 mo. tower controller.



THIS IS CONSIDERED TO BE A CREDITABLE STATEMENT

TaJ-1 BuNo 148222 was accepted new by VT-7 on 13 January 1961. A special inspection in accordance with CNATRA Instruction 3110.2 dated 10 October 1958 was performed. Since this inspection the aircraft has undergone the following periodic inspections.

Intermediate - 12 Feb 1961

1st Major - 15 Mar 1961

Intermediate - 18 Apr 1961

It was discovered on 14 May 1961 that this aircraft had a cracked funelage frame upon commencement of the 2nd Major inspection. This inspection was terminated and the aircraft was prepared for a one-time flyaway to O&R at NAS Pensacola. It had 4.4 hours remaining to complete the ferry flight with 60.6 hours flown since last inspection.

Tal-1 BuNo 148222 accumulated 245.4 hours between 13 January 1961 and 25 May 1961. The history of this aircraft shows no discrepancies related to the accident. It had no record of elevator control malfunction.

T2J BuNo 148222 was transferred from 4-3 to H-6 status on 15 May 1961 awaiting transfer to Pensacola. The aircraft had a routine daily and pre-flight inspection on 25 May 1961 prior to departing on the flight.

The following components were removed and emergency DIR is being conducted by NAS Pensacola OFR.

- 1. Fuel Control
- 2. Fuel Pump
- Elevator Boost Package

Results of the DIR, if appropriate, will be forwarded as an addendum to this report.

The aircraft engine was disassembled and inspected by VT-7 under supervision of the PRATT & WHITNEY Factory representative. No indications of engine malfunction were noted.

A complete review of all work orders and yellow sheets reveal no discrenancies which would require the seats of T2J-1 BUNO 11,8222 to be pulled with the exception of the first major inspection completed on 15 March 1361. In addition there were no work orders or yellow sheet squawks which would require disconnection of the high pressure gas line to the canopy. This item is also spelled out as a check to be accomplished on major inspections. From the above, the following can be concluded:

- The only time the seat was removed from the aircraft or worked on was during the first major inspection.
- The high pressure gas lines to the canopy jettisoming device were signed off as being secure, reference item 1 of the Safety and Survival section of HIR.

As for specific inspection requirements of the seat the following is the

1. Item um of the Safety and Survival section of the HIR calls for inspection of the aneroid mounting, arming pin, and thruster rod for security. This does not spell out an inspection of the bell chank or bell crank pivot pin. However, with the seat removed it is felt that any outward irregularity in this area would have been noted. Records indicate that the following men worked on the entire Safety and Survival section of the first major inspection of this aircraft in the following capacity:

(b) (6) AA Performed Work
(b) (6) AME3 Systems Inspector

Records available in the Enlisted Personnel Office indicate (b) (b) was assigned to the Airframes Division of the Maintenance Department. Records are very limited as to (b) (6) qualifications. These qualifications can only be obtained from personnel previously detached. However, (b) (6) recalls (b) (6) on-the-job training and states he was well trained and was well qualified.

(b) (6) attended and graduated from AME(A) School. On 19 April 1961 was given an examination for Oxygen System Inspector in T2J-1 aircraft. A grade of 3.6h was attained. His nomination was signed by (b) (6) and approved by the Commanding Officer.

performed the only inspection accomplished on the rear ejection seat, and canopy system.

(b) (6) signed off the first major inspection as a complete Safety and Survival Systems Inspector when he had only been designated as an Oxygen Systems Inspector. However, all indications from squadron personnel in a supervisory capacity claim (b) (6) to be qualified and trained to perform this work even though present procedures to designate him as such had not been accomplished.

Sixty hours subsequent to the first major inspection where the seat was pulled for the only time a second intermediate inspection was completed on 18 April 1961. The Safety and Survival section of this inspection was performed as follows:

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 70

Page 1 of 3 pages.

VT-7 AAR Ser 6-61 cor accident occurring 5-25-61 Pilot

AMS2

Performed Work Systems Inspector

califications of Whese nersero follow:

AMS2

Reported abound 14 May 1959

16 Dec 1959

AMSAA AMS3

Designated Designated

16 Nov 1960 AMS2

Schools attended:

A/P Graduated 49 in class of 92 23 Jan 1959 AMS(A) Graduated 14 in class of 20 17 Apr 1959 NAMO TRA DET T2J-1 (A/F) Jul 1959

Systems Inspector: T2V-1 Oxygen system. Score 3.5

Designated 22 Jan 1960

Started working in AME Shop in October 1960

AM2

Reported aboard

31 Oct 1958

AMSAA

Designated

16 Jan 1959

AM33

Designated

16 May 1960

AMS?

Schools attended:

A/P Graduated 55 in class of 143 AMS(A) Graduated 13 in class of 31 18 Jul 1953

NAMO TRA DET T2J-1 (A/F)

Oct 7958

Systems Inspector: T2J Airframes systems axam.

Jel 1/50

Score 3.5 Designated 22 Jan 1960

Started working inAME Shop in November 1960.

Item 2 (e) of the Safety and Survival section of the Intermediate Inspection calls for an inspection of the aneroid mount, arming pin and thruster rod for security. This area encompasses the bell crank which had the missing pivot pin. Both the person performing the work and the person performing the inspection are confident that the pin was installed at the time of this inspection.

and (b) (6) are considered highly qualified and conscientious performed this inspection.

It is the Maintenance Officer's opinion that the missing bell crank pivot pin was installed at the factory with the cotter key end facing inward and was at least partially in the boll crem' mivot point at the time Had of the first major and the second intermediate inspection. it not been in, it is felt that an obvious misalignment of the bell crank would have been noted.

Indentations and red paint from the washers indicate that a pin had been installed at one time and that a cetter key was used, although not necessarily bent for security. In view of the above it is felt that most probably the pin backed out of its retniner during the last 60.5 hours of flight because of constant insertion and removal of the safety pin.

There is nothing factual from available records that would lead to an answer as to why the gas line was disconnected. It was required to be imspected only during the first major, (b) (6) had signed the work order as having performed the work and (5) (6) had signed as Systems Inspector had signed as Systems Inspector as having performed the work and

SPECIAL HANDLING REQUIRED ACCORDANCE WITH PARA 70 OPNAVINST 3750.6D

Page 2 of 3 pages

VT-7 AAR Ser 6-61, 0 ern of the train 11222 acci t occurring 5-26-61

for the work. (b) (6) cannot remember this aircraft but states that he informaliar with the importance of this particular inspection, and actually makes the inspection when he is acting as Systems Inspector. However, records do not indicate any work done in the gas line after the inspection by (b) (6) and (b) (6) . It must be concluded that the line was disconnected at the time of the check but was not moted by either (b) (6) or (b) (6)

ORIGINAL

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 70 OPNAVINST 3750,50

6-190%	Tank Rusted	Out	-1-	59	Weiti	ne on instr	uctions for dispes			
2-00877	011 Look -	Main Engine	-		In pr	*****	- C - 100			
7-00655	Automatic C	hole & Fuel	Look	1	In pr	*****				
Bal				-	261 Funds received 5-25-61 for repair					
B-1 1-00524	Complete Me	tor Overhaul		283						
TYPE		DEFICIENCY	M EQUIPMENT	NO. OF DAY		EXPLAIN DELA	IVS TO REPAIR			
		******	M EQUIPMENT	OUT OF S	EBVICE					
	-	8 8		CLOS		(2)	_			
type	NO. LOADS USED	MIL.	CIV.	(gale	FOAM . come. as	ed) OTHE	OTHER TYPES AND QUANTITIES			
	AT INCIDENT	NO. PERSON				TY EXTINGUISHING	AGENTS USED			
			STATION E	QUIPMENT						
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. WAY RADIO		T METHOD OF ALARM	191	ENCY PHONE	X		NE RECORD			
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isibility			LOCITY (aph)	7 Knote		Rough Te	rrein			
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NDING	PARKED	MAINTENANCE	NO INPLACE							
E-OFF	I LINE OR LOADING	FUELING	YES	100	o be de	termined by	AR Roard			
	TYPE OF INCIDENT	,	FIRE INVO	OLVED ST	MATED CASE					
SI ONA TURE										
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	ureau of Naval W	eapons (SEEQ)					s south of roll-of			
1-7				1-2-1		EXACT LOCATION	1/8555			
SET ING CUSTOD I AR				MODEL ALRCH	AFT INVOLVED		NAME OF THE PARTY OF			
ingsville	al Auxiliary			25 No	r 1961	0849	OFF STATION			
		ALF STATION		DATE AND TH	ME OF INCIDEN	*	ON STATION			
S. Rew	at twelltown	UK	IGINAL	26 Ma	y 1961		10-61			

DESCRIPTION OF DIFFICULTIES IN FIRE CONTROL AND EXTINGUISHMENT DUE TO UNUSUAL CONDITIONS OR EQUIPMENT AND/OR AGENT INADEQUACIES

Difficulty was encountered in reaching the crash site due to heavy undergrowth brush and rough eroded condition of terrain. Aircraft landed in washed out gully approximately twenty feet wide and fifteen feet deep.

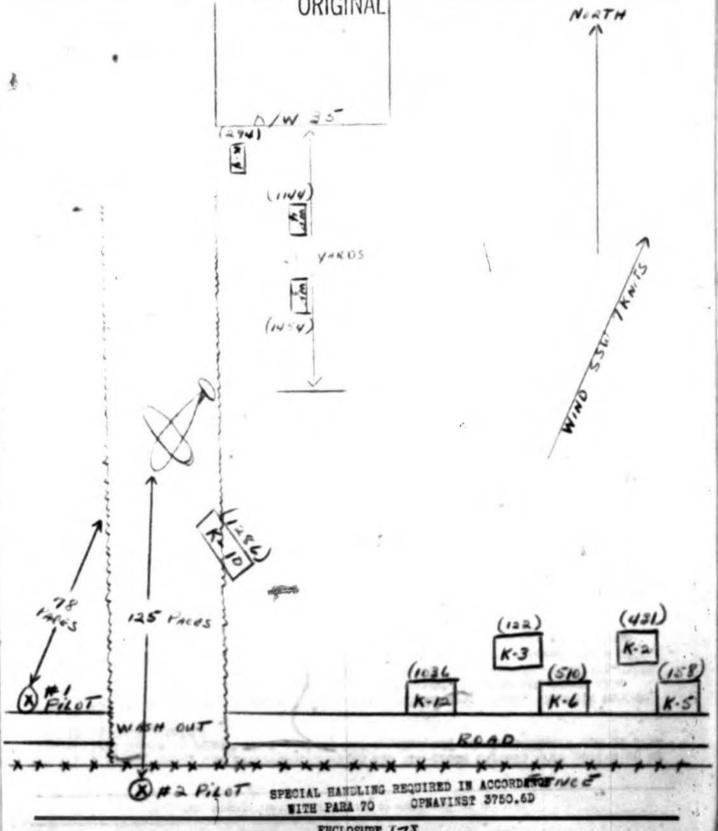
RECOMMENDATIONS FOR IMPROVEMENTS IN EQUIPMENT AND/OR PROCEDURES TO INCREASE EFFICIENCY

加螺

Orig & 1 SEEQ Via CNAVANTRA CNATRA AAR BOARD (VT-7) CENTRAL FILES CRASH OFFICER OPERATIONS OFFICER

mined by A	AR Board	mined by A	B Board	-	THE PARTIES AND EN AL	
25 May 61	(b) (6)	Crash Cap	e. 08-6	SIGNATURE		
1 MAY 1961	CAPT USS	and the same of th	SPECI	L HANDI	REQUIRED IN ACC	

DIAGE OF INCIDENT SHOWING WIND, DIRECTION, A DACH OF EQUIPMENT, POSITION OF AIRCRAFT, DISTANCES, ETC. (Sape and photographs should be included, if significant)



ENCLOSURE [71

At OSk9, 25 May 1961, the intercommunication and the crash circuit were activated by South Field Tower to report that a plane had crashed off of the roll-off end of run-way 17 at South Field.

MB-5 #71-01286 was on the hardstand observing sirfield operations. Aircraft number 116222 was observed rolling off runway 17 at high speed, Grow on the truck also noticed what appeared to be two ejection seats leaving the sircraft. MB-5 #71-01286 responded immediately toward sircraft and reached crush area at approximately 0550. The truck made setup position southeast of sircraft due to extremely precipitous terrain conditions and extinguishing procedures were started immediately.

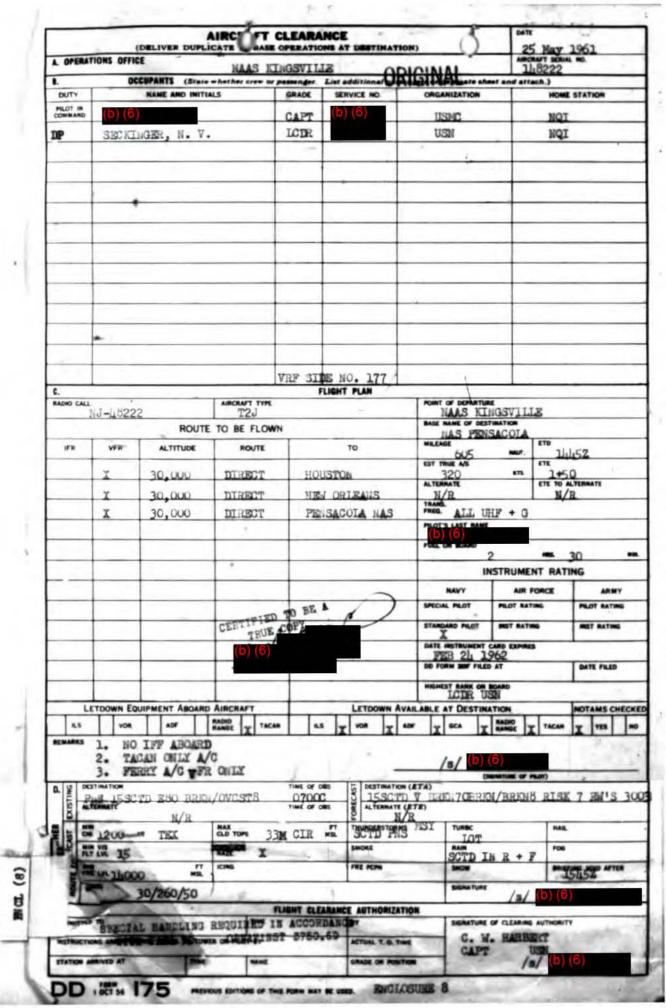
MB-5 #71-01036 arrived at crash scene at approximately 0051. The Grash Captain and crew from MB-5 #71-01286 immediately located both pilots of aircraft. Filet #1 was located approximately 78 paces southwest of aircraft; Pilot #2 was located approximately 125 paces south of aircraft. Number 1 was fatally injured. Pilot #2 was seriously injured and administered to by the Medical Officer at the scene.

Approximately 20 minutes elapsed when Fire Chief's pickup #96-31631, Assistant Fire Chief's pickup #96-29122, and Structural pumpers #73-01166 and #73-01656 arrived at the scene. Both Structural pumpers setup positions northeast of aircraft and assisted crash crow. Firel extinguishment was accomplished at approximately 0916.

After fire was extinguished all equipment, except NB-5 #71-01036, was secured from emergency. MB-5 #71-01036 stoodby while investigating officers at crash seems investigated.

Extreme difficulty was encountered in reaching aircraft due to heavy brush and large washouts around aircraft and on base road.

EACH, BO	HIPMENT INCIDENT	MO. PERSO MANNING BO		QUANTITY EXTINUUISHING AGENTS USED							
TYPE	NO. LOADS BEED	1617	civ.	FOAM (gals.come. used)	OTHER TYPES AND QUANTITIE						
Pickup Pickup Power Wagon Power Wagon MB-5 B-5 MB-1 Pumper (7500PM)		1	1 1 1 1 5 5 5	None None None 20 gallons of foan Hone None	None None None None Sone 600 gallons of water 200 gallons of water None None						
ORIGINAL		•									



KESENDE?	HAI Pensecola		6-12-61	Puel Purp						
00 1007 981	SIR 408	\$77200	5-25-61	MOD #	4-12-45	· # 220				
251.4	12. HOURS EINCE LAST O.W	13. DATE LAST DAY	14. LAST OVERHALL	ACTI YI TY						
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1. Disamsembly external and in 2. So indication to BUHEFO (FHAE-4) HOWEFO (RAPH-2) HAVAVSAFCEN SUMMERS HEF HAST CHARATEA	on of malfunction	or material SPERSFULES VI-7 (A/C VI-7 (AVIA SUMMINGER	failure was UPUEP CEN MAINT OFFER TION SAFETY COLUMNIS	found. R) OFFICIE	90. 90.	HARTS REMOVED AREA SALE CORE TO VILLER	CIMB.			
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NAS Per		989	6-12-61	4 ASSEMBLY	outrol		
MOD 1097632	52141 0	66503	5-25-61	**** 334*	4	10. ENGINE	den
231.4	12. HOLAS SHICE LAST OF		14. LAST GVERHAUL				PMY. OAT
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conductions (Pare.	Nos. correspon	d to paragraph :	nusbors unde	- Finding	=)		43
1.	emited from fi	re after socider	nt.			11 - 30	
NA COMMENCATIONS [CODE	1					7. 1.3025	
1100 Table (b) (6))	PRIOR	ITY -	DIR		4	
	Section 1		" Atto. De	. Supt.	17 N. Take	"60	
SASSEMBLY AND INSPE	CTION REPORT MANEE	1-2461 (REV. 12-64)	100		****	1 200	March.

MEDICAL OFFICER'S REPORT OF A/C ACCIDENT. INCIDENT. OR GROUND ACCIDENT - PAGE 1

OFFICER'S REPORT OF A/C ACCIDENT. INCIDENT. OR GROUND ACCIDENT - PAGE 1

OFFICER'S REPORT OF A/C ACCIDENT. INCIDENT. STREAM OF STREAM O

(CONTINUATION OF SECTION A, #30, VT-7 MOR 6-61)

CAPT (b)(6) requested and received clearance for take-off. As he taxied into position for take-off, he closed the canopy and locked his shoulder harness and put the flaps up for a flaps up take-off.

CAPT (b) (6) applied full throttle control while holding his brakes and as soon as the engine tachometer indicated 100% RPM, CAPT (b) (6) released the brakes and started the take-off roll.

CAPT (b) (6) noted the oil pressure was low (estimate 70 LES pressure) and tried to tell LCDR SECKINGER in the rear cockpit about it. He held his oxygen mask over his face with his left hand as he pushed the intercom switch to "CALL" but was unable to get a response from LCDR SECKINGER. The other instruments indicated the engine was operating normally.

LCDR SECKINGER spoke on the intercom shortly after this, but CAPP (5) (6)

The take-off roll continued until 100 kts was reached and GAPT (b) (6) tried to raise the nose to take-off attitude. The nose would not come up even though an airepeed of 110 to 115 kts had been attained. GAPT (b) (6) tried a second time to raise the nose to take-off attitude, but to no avail.

When the nose did not come up on this second attempt, GAPT (D)(6) decided to abort the take-off. He reduced power to idle, turned off some switches and reached for the hook, but he saw he was past the runway arresting gear. He pulled the stick full back and applied full brake and saw he couldn't stop the aircraft before going off the end of the runway.

Inasmuch as there was no rummay over-run, CAPT (b) (6) pulled the ejection curtain at the end of the runway. The ejection control was in the front cockpit and both pilots were ejected through the canopy.

GAPT (b) (6) section of the ejection system worked as it was designed to do, with the exception of the canopy. The distance from point of initiation to touchdown was 62h feet. IGDR SECKINGER went 599 feet from the end of the runway in the seat. Seat separation did not occur due to the fact that the striker air pivot clevis pin in the amercial linkage was missing.

The aircraft relied off the end of the runny into a deep gully and came to rest 491 feet from the end of the runny. The aircraft caught fire immediately. The crash erew arrived on the scene shortly thereafter and took charge.

SECTION C - PHYSIOLOGICAL. ...MAN ENGINEER'NG, DESIGN, SOCIO-PSYCHOLAZICAL, AND TRAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT

NAME OF INDIVIDUAL (Last, first, siddle) Check E-Established, S-Suspected, or P-Present for each factor selected. Additional SXION plain sheets will be used for the sup porting account of items checked below. Identify each statement with the factor and section identification (e.g., Cl. C2, etc.). Attach all sheets pertaining to these factors to this form upon completion. ESP ESP J FACTORS J FACTORS SOCIO-PSYCHOLOGICAL: (Entired stress free daty or PHYSIOLOGICAL: 1. Physically incapacitated in flight 29. Expeditings/Delays 2. "G" forces 30. Weather 31. Machanical Problems 3. Environmental stress - External 32. Social and working relationships - Internal 5. Dyabariam/esplosive decompression 33. Personal confort 6. Diet 34. Regulations 35. Facilities 7. Fatigue 36. Navigation 8. Hypexis 9. Related illness 37. Duty assignment 10. Vertige/Disorientation/Illusions 38. Personality traits NON-STRESS FACTORS: 11. Hyperventilation 12. Drugs 39. Faulty attention 40. Poor judgment (See Section E. Par. 13. Physical state 14. OTHER: 41. Forgetfulness 2a, 2b, 20, 2d, 2e)
42. OTHER SOCIO-PSYCHOLOGICAL FACTORS 41. Forgetfulness HUMAN ENGINEERING AND DESIGN: 15. Personal equipment 16. Displays and/or controls 17. Work arrangement 18. Working environment 19. Habit interference TRAINING FACTORS: 43. Physiological training SOCIO-PSYCHOLOGICAL: (Emittenel stress from non-daty sources) 44. Emergency Procedures training 45. Survival and rescue training 21. Pregnancy 22. Illness or death 46. Refresher training 23. Arguments 47. Transition training 24. Elsted/Depressed state 48. OTHER: 25. Personal habits - Drinking 26. 27. - Gambling 28. - Debta SECTION D . AIR CREW DATA (fill in where applicable) 1. Plight time past 30 days 7. Total time in model 30..3 2. Flight time last 24 hours 8. Number of days grounded last mouth, give reason 3.0 3. Number of flights in last 24 hours 4. Time at controls this flight 9. Number of and dates of previous accidents 5. Number of hours duty last 24 hours

SECTION E - CONTRIBUTING FACTORS AND THEIR ANALYSES (As condensed from Part 1, Seats & and Part 1311 of the AAR)

NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A, i.e. 15(a). Attach additional sheets as necessary.

SHE ATTACHED SHEETS.

6. Total flight time

MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT-Page 2

OPNAV FORM 37,50-8A (REV. 5-58)

OPNAV REPORT 3750-7

SECTION C-PHYSIOLOGICAL HUMAN ENGINEERING, DESIGN, SOCIO-PSYCHOLOGICAL AND RAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT

NAME OF INDIVIDUAL (Las, firs, middle)

T2J-1

SECKINGER, Neil Vincent

Check E-Established, S-Suspected, or P-Present for each factor selected. Additional 8X10½ plain sheets will be used for the supporting account of items checked below. Identify each statement with the factor and section identification (e.g., Cl, C2, etc.). Attach all sheets pertaining to these factors to this form upon completion.

P	✓ FACTORS	E	S	P	✓ FACTORS
P	HYSIOLOGICAL				SOCIO-PSYCHOLOGICAL! (Emotional stress from ducy sources
	Physically incapacitated in flight				29. Expeditings/Delays
	2 "G" forces				30. Weather
	Environmental stress - External				31. Mechanical Problems
	4 - Internal				32. Social and working relationships
	5 Dysharism explosive decompression				33. Personal comfort
	h Diet				34. Regulations
	Fatigue				35. Facilities
	8 Hypoxia				36. Navigation
	W Reinted illness				37. Duty assignment
	10 Vertigo/Disorientation/Illusions				38. Personality traits
	11 Hyperventilation				NON-STRESS FACTORS:
	12 Drugs				39. Faulty attention
	13. Physical state	×			40. Poor judgement (See Section E, Par.
	14 OTHER:				41. Forgetfulness 2a, 2b, 2c, 2d, 2e, 42. OTHER SOCIO-PSYCHOLOGICAL FACTORS
141	MAN ENGINEERING AND DESIGN				42 OTHER SOCIO-PSYCHOLOGICAL FACTORS
	15 Personal equipment				
	to Displays and/or controls				1
	7 Work arrangement				
	8. Working environment				
	14 Habit Interference				TRAINING FACTORS:
	20 OTHER:				43. Physiological training
50	OCIO-PSYCHOLOGICAL: (/ munoru) attat from non-duty seut. (s)				44. Emergency Procedures training
	21 Pregnancy				45. Survival and rescue training
	22 Illness or death				46 Refresher training
	23. Arguments				47. Transition training
Ť	24 Elated/Depressed state				48 OTHER:
T	25. Personal habits - Drinking				
	26 - Sex				
	27 - Gambling				
	28 - Debts				

Flight time past 30 days	14.6	7. Total time in model 77.3
2 Flight time last 24 hours	0.0	8. Number of days grounded last month, give reason
Number of flights in last 24 hours	0.0	0
4. Time at controls this flight	0.0	9. Number of and dates of previous accidents
5. Number of hours duty last 24 hours	8.0	One accident (engine failure): 2 Nov 19hh
6. Total flight time	1036.S	THE RCLP

SECTION E - CONTRIBUTING FACTORS AND THEIR ANALYSIS (As condensed from Part I, Sect. D and Part VIII of the ARR)

NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A. i.e. 15(a). Attach additional sheets as necessary.

SEE ATTACHED SHEETS.

 THE TAKE-GFF - In view of the flaps up take-off test conducted and the flaps up take-off information received from the Field Engineering Trainer Group, MAA, Columbus, Ohio, this aircraft should have become airborne when the stick was brought back to the take-off attitude.

The board was unable to determine the cause for the failure of the aircraft to assume a take-off attitude beyond the possibility of a failure or malfunction in the elevator control system. The elevator hydraulic boost actuator is being sent to 0 & R, Pensacola for DIR. The hydraulic lines on this actuator sammet be hooked up backwards due to non-compatible fittings.

The control linkage in the cockpit areas was completely destroyed by the fire. The cause for the failure or malfunction of the elevator control system is therefore undetermined.

2. Procedures used.

- a. The pre-taxi check-off was performed while taxiing out, which was in violation of the squadron's operating procedures.
- b. The speed brakes not extending is reason enough for the pilot to down the aircraft for the following reasons:
 - (1) The pilot did not know the reason the speed brakes would not extend.
 - (2) The speed brakes not extending could be a possible indication of a failure in the hydraulic system.
- c. The pilot started his roll for take-off without checking all of his engine instruments. The pilot should not have started a take-off roll with the oil pressure gauge indicating low oil pressure (70 lbs). Minimum pressure for 100% is 11h lbs. Starting the take-off roll prior to checking all the engine instruments is in violation of the squadron's operating procedures.
- d. The decision of the pilot to make a flaps up take-off on a 6000 foot runway was very unrise and in violation of the squadron's operating procedures. The position at which TAIX-OFF was initiated was approximately 500 foot from the take-off and of the runway, therefore, the runway available for use was 5,500 foot.
 - (1) The take-off distance for flaps up, under the conditions this attempt was made was a maximum of 3000 feet. The minimum stopping distance from 135 kts is 2320 feet. This requires 5320 feet of runnay for take-off and about without hesitation or indecision on the part of the pilot.

- (2) The take-off distance for flaps down under the conditions this attempt was made requires a roll distance of 2300 feet and a lift off speed of 98 kts. The minimum stopping distance from 98 kts is 1720 feet. This requires \$1020 feet for take-off and abort. This would leave 1\$180 feet of spare runway and if the abort had been done without hesitation, the aircraft could have come to a stop in the arresting gear, which is 1500 feet from the end of the runway. It is felt therefore that had a flaps down take-off been attempted, this accident could have been averted.
- e. Neither pilot had his oxygen mask on which is in violation of Training Squadron SEVEN Instruction 10127.18 which is quoted in part "All personnel will wear the following items of flight clothing while flying in the T2J-1 aircraft: f. Oxygen mask from takeoff to landing." (See enclosure 3A)

The pilots not having their masks on and being on cold mikes definitely added to the confusion during the take-off, when GAPT (D) (6) was unable to get LCDR SECKINGER's attention by clicking the intercom switch to "CALL" position.

All the above listed violations definitely added to the confusion of the take-off and possibly hindered the pilot from making the correct decision at the right time when the difficulty of not being able to raise the nose was encountered.

The ejection system.

- a. The ejection was through the canopy due to the fact that the gas line to the canopy actuator was not attached. This item is on the maintenance major check sheet and was signed off as having been CHECKED on this aircraft during the last check.
- that the pivot pin in the striker bellerank was due to the fact that the pivot pin in the striker bellerank was missing at the time of ejection (See encl. SM & SM). There is evidence of wear in the striker bellerank pivot pin hole indicating that the pivot pin had been installed at one time. Since there were no work orders issued requiring removal of this pivot pin, it is believed by the board, that this pin was not properly secured by a cotter pin at the time of installation or it was removed and reinstalled insecurely or not reinstalled at all without a work order being issued. All other seats of this squadron was imported for missing pivot pins and all pivot pins were found in and properly secured. The maintenance inspection check short lists the amoraid area as a check item, but does not spell out the items in this area, one of which is the anchor pin for the striker bellerank.

(CONTINUATION TO SUPPLEMENT TO PAGE 2, SECTION E, VT-7 MOR 6-61)

- c. Front seat. Everything in this seat system functioned as designed. It could not be determined as to how the "D" ring was pulled, but the initiators were fired. The pilot states he only pulled the curtain.
- d. Oxygen masks.
 - (1) Neither pilot had his oxygen mask on completely. They were hanging by one Hardeman fitting from the helmet.
 - (2) The bailout bottle lasts from 2 to 3 minutes after ejection.

 CAPT (b)(6) was knocked unconscious when he hit the fence and by the time assistance arrived, it is believed he would have suffocated, had he had his mask on correctly. Since ground level ejections can end in rough terrain and the pilot can be injured there is a need for automatic release of the mask or some automatic device to let outside air into the system when the bailout bottle is empty after ejection.

ne or individual (Last, first, middle)								800EL 1/C
5) (6)	AV	AIL.						723-1
GENERAL DESCRIPTION OF EQUIPMENT		₩.	MODEL OR TYPE	TES	BO	TES	HO.	DESCRIPTION OF DAMAGE TO EQUIPMENT
Shoulder harness	×		18-7 Par.Int.llarmon	H			×	
Lap beit	×		Int. WA 249-530-12	H	- 4		-	
Inertia reel	x		Talco-co Ballistic	X			-	
G-Suit .		x	Not necessary]
Pressure suit-full or partial		x	Not necessary					
Exposure suit	_	×	Not necessary					
Flight suit (Other than above)	×		Summer Flying	X			×	
Helmet	×		Air Force P-UA	X			×	See Encl. 51 and 53
Goggies/Eyeshield	×		Air Force P-M	X			-	See Engl. 5I and 53
Shoes	×		Boondonberg	×			X	
Gloves	X		Summer Flight Glove		×			Habitually not put on by
Life vest		×	Not necessary					this pilot until A/C is
Life raft	x		MK III		×			airborne.
OTHER:	+	-					-	
SIGNAL DEVICE - Flare (Night)			MK-13 MOD O					
- Flare (Day)			ME-13 MOD O					
- Dye marker	-		PSN -RF-6850-285-800					
- Radio	-		Not termed					
- Flashlight		-	Not processary					
- Mirror		_	MK III					1
OTHER:	-]
SURVIVAL GEAR - Knife		-	Survival					
- First sid kit	-		Eit. First Air Aero	100	Ma	(m	43	sed - no)
- Shelter	-							
- Food]
OTHER								
RESCUE - Vehicle	-		IEN Ambulance					
- Sling, Net, Stretcher	1-							
OTHER		- 5						
			SECTION G . DETAILED EQUIPME	NT Q	UEST	IONN	AIRE	
1 MASK - MODEL OR TYPE	2. 1	BODIFIC	CATIONS, IF ART					
A3.24	_	Ψ.	N-ma					
a VEVELATOR - MODEL OR TYPE	4.	MODIF	EXTIONS, IF ANY					
Robertshaw-Fulton		one						
Folgation Falton	IF MO.	-	01				7. LH	ST DISCREPANCIES MOTEO ST PREPLIENT CHECK
								None
. OXYGEN PRIDE TO PLIENT			TIME OF ACCIDENT					ACCOT. THE OF
SUPPLY: LITERS !	-		ALL GENER COUPMENT DECESSARY FOR					
10. 17 165, WAS SELECTOR SETTING	- 11		11 C 10 10 10 10 10 10 10 10 10 10 10 10 10	1816	-	****		17 80. LIST ITEMS 280 SEASON BUT.
	_	_		_				
			LIGHT! IF TES. GIVE DUBATION AND BEAU					
13. TIPE CHUTE BELEASE BEVICE	يجدء	ch	d sheet		-			
	1"		MARKEN BELGARE BENEEL 16.				-	EVICES ACTIVATED?
Personalitie Release		Int	ST STREET WHEN STATE SUPPLEMENTED		#	44	ĮŢ.	After ejection
			- In the surface of	17	-	-		
		ACTO	NATION DELEME DEPICEDY OF YES, STATE	-	CRATIC		to C	COUNTERED AND CAUSE.
П. П.		-	797.12					
			the second of th		- 40	man.		the same of the sa

(b) (6)

0-12

Neither pilot had his exygen mask on which is in violation of Training Squadron SEVEN Instruction 10127.18 which is quoted in part "All personnel will wear the following items of flight clothing while flying in the T2J-1 aircraft: f. Oxygen mask from take-off to landing." (See encl. 3A).

CAPT (D)(6) could give no explanation for not utilizing his oxygen equipment.

	live ac		ON F - SAFETY, PERSONAL, AND of damaged or falled items. Iden						
LE OF INDIVIDUAL (Last, Sest, middle)								1	BOOKL D'C
ECKINGER, Neil Vince	T AV	ATL:		write	IZEO		LED		174-1
GENERAL DESCRIPTION OF	YES	NO.	MODEL OR TYPE	768	_	788	80	DESCRIP	TION OF DAMAGE
Shoulder harness			VR-7 Per Tet Harmon	-	_	-	×		
Lap belt	12		Int. MA 21-5-530-121	•			÷		
Inertia reel	1÷		Falcoure Ballistie	÷			î	1	
G-Suit	1-		Not peoppeary	-			-	1	
Pressure suit-full or partial		-	ot recessory		-			1	
Exposure suit	1	-	lot messary						
Flight suit (Other then above)	-	-	Summer Flying					Seat tered	teers
Heimet	10		PL	-				See encl.	
Goggles/Eyeshield	12		PR-S	•				See engl.	
Shoe	12		Boondooks 29	•			î		
Gloves	12		Summer Flight Cloves	Ŧ			ī	1	
Life vest	1		lot necessary	_			-	1	
Life raft	×	-	A III				- 1	1	
OTHER:	1-				-		1	1	
								1	
SIGNAL DEVICE - Flare (Night)	×		W-13 NGD 0		×			1	
- Flare (Day)	1		KK-13 MOD 0		=			1	
- Dye marker	1		SH-RF-6850-285-8000		1			1	
- Radio	1	×	lot issued					1	
- Flashlight		-	Not recessary					1	
- Mirror	-	-	III		-			1	
OTHER:	1				_			1	
SURVIVAL GEAR - Knife			Survival						
- First aid kit	-		Kit, First Aid, Asre	-	210	(1	117	ised - no)	
- Shelter									
· Food								1	
OTHER:									
RESCUE - Vehicle	×		SN Ambulance						
- Sling, Net, Stretcher									
OTHER									
			SECTION G . DETAILED EQUIPME	NT Q	UEST	IONN	AIRE		
1. BASE - BODEL OR TIPE	1. 1	HODIFIC	ATIONS, IF ANT						
4134		ions.							
3. MEGLATOR . MODEL OR THPE		BOOIF	CATIONS, IF ANT						
Robertshow-Full ton		-							
	W #0,		or .				7. LH	ET DISCREPANCIES NOTI	
THE DESIGNATION OF THE PERSON									
S. PREPLICATED BY USER? TES BO BO TO FLICHY OCTUBER FROM TO FLICHY SUPPLY: LOS LITERS FO			TIME OF ACCIDEN	•				9. WAS O	***************************************
SUPPLY: LITERS /			P.S.L. (Ges)					L. (Ges)	100
10. IF YES, DAS SELECTOS SETTING	1		ALL OXYGEN COUPMENT NECESSARY FOR	THE	PLISHT	AVAI	MBLE	I IF NO. LIST ITEMS A	
			. U .						
The Table	-		MENT IF YES, SITE SUBSTION AND REAS	04.					
	-	يعف	sheet			-			
IS. THE COUTE SELENCE SERVE	Т"		MARKEN SELENSE DEVICE 15.		witne	MALE	ASE D	EVICES ACTIVATED!	
Proposition Paleston	1	Į,	control house	Hot		44.	-	4	
		MECER	SO DESIGNATION OF THE PARTY BUTTERLY IN			-	tate.	AND CAPPE.	
L		-				_	_		
	- APTER	LACTIV	ATING RELEASE DEVICES? IF TES, STATE	Barri	COLTH	ES. W1		COUNTERED AND CAUSE	
17. WENE DOTTENLTIES ENCOUNTERE									
O O-								V	
O O-		M T ING	MALANE DEVICED IF TES, WHAT SIFT	W.THE	1 100	THIS !	Manu	es	14 12

SUPPLEMENT TO PAGE 3, SECTION G, VT-7 MOR 6-61 (SECKINGER)

G-12

Neither pilot had his oxygen mask on which is in violation of Training Squadron SEVEN Instruction 10127.18 which is quoted in part "All personnel will wear the following items of flight clothing while flying in the T2J-1 aircraft: f. Oxygen mask from take-off to landing." (See encl. 3A)

SECTION SECTION	G - DETAILED EQUIPMENT	QUESTIONNAIRE (Comis.	1	MODEL A/C
6)				12J-1
	10 INTEGRATED!	21. BOOLFICATIONS, IF ANY S	TATE SEASON	77
NB-7 Par. Torse Harmess	FULL PARTIAL	Rocket Jet Con	mecter Rev	beer
J DIO INTEGNATED HANNESS FIT PROPERLY) IF NO. J INTEGNATED HANNESS FITTING WAS COMBUCTED B		AVIATION EQUIPMENT OFFICER	OTHER	
E LOCRED UNLOCKED TIGHT S. TYPE HELWET 26 LIST PRESCRISED	BLACE OT	ER CONDITION		
Air Force P-14 Hardenan 1		DID HELMET FIT PROPERLY! IF A	DA GIVE BEARDS	
		X ves		
WEARER FLIGHT SURGEON	PARACHUTE RIGGER	AVIATION EQUIPMENT OFFICER	-	
NB-7 27 March 6			보고 이 이번 그들은 아르지 않고 있다면서 하나 있다.	talty 1000-6
BID AUTOMATIC RIPCORD FAILT IF YES, WHY?			MANUAL	
TO DID CHATE OPEN INNEDIATELY! IF NO. GIVE REASO		-1		UDE THAT CHUTE OPENED
E RES NO	40 BOST ATTITUDE AT OF	ENING THE CONDITION OF	CHUTE AFTER OPERIO	sted 35 rer
SLIGHT MODERATE SEVENE	Horisonta	l Hornel		
R NORE SLIGHT MODERATE	SEVERE 45 # 050	ILLATION WAS PRESENT, NOW WAS	# #TOPPED!	
Visual Flight Rules	iequence)	Brosion ditches,		min, trees.
S WAS BAILOUT OFFSEN CONNECTED!	17 WAS BANGO			brief
S WHEN WAS IT ACTIVATED!	49. GIVE DIFFICULTIES ENCO	NO PILOT NOT WEE		ART
D WAS CHUTE HARRESS	SI WAS A SITTING POSITION	IN SLING OSTAINED DURING DESC	ERT! IF NOT. WHY!	
TIGHT SHUE LOOSE	12 WAS CHARACT MAYAGO	ATTEMPTED COMMECTED TO LIFE YEST D SING	1 15 801 822	
Seat Pan	NO TES			
	ro, morde, and	hot: Squadron le	ctures	
HELEASE ACTIVATED SUCCESSFULLY	165 0 80 S4 17 1	IO, GIVE REASON		
7 IF C BUIT. EXPOSURE SUIT, FULL OR PARTIAL PRO THEREFOR 153 80	SCORE SOIT WAS WORK, SID IT	FIT PROPERLY: W MOT, LIST D	ISCAEPANCIES IN FIT	AND GIVE READORS
WAL S. SUIT COULPPED WITH A SPECIAL LOADED SIGN	ORNECT ADAPTED? IF NO. SIVE	REASON		
S. LIST ALL ITEMS OF NON STANDARD CLOTHING ON S	-			6
	ITEM, WHEN LOST, AND 61.			f ITEM, WHEN DISCARDED
	STATE OF THE	C C		

(*)

SUPPLEMENT TO PAGE h, SECTION G, VT-7 MOR 6-61 ((D) (6)

0-60

CAPT (b) (6) Air Force hard hat (P-hA) was found approximately 15-20 feet away from him when the reporting Flight Surgeon reached him. CAPT (b) (6) elected to use the Air Force hard hat in preference to the standard Navy APH-5 by reason of not being able to achieve a proper fitting with the latter. It should be noted that said Air Force hard hat did not have a chin strap. The reporting Flight Surgeon feels that the lack of a chin strap and non-utilisation of the Hardeman fittings were responsible for the loss of CAPT (b) (6) hard hat. It is probable that GAPT (b) (6) lost his hard hat on contact with the fence surrounding the reservation, immediately prior to contact with the ground.

MEDICAL OFFICE®'S REPORT OF A/C ACCIDENT, INCIDENT, GROUND ACCIDENT - PAGE 4 OPNAY FORM 3750-8C (5-58) OPRAN REPORT 3760.7 SECT . G . DETAILED EQUIPMENT QUESTIONNAIRE (Continu MODEL A/C NAME OF INDIVIDUAL (Lost, first, middle) SECKINDER, Neil Vincent NB-7 Par.Torse Harmess Rocket Jet Connector Reversed DID INTEGRATED HARMESS FIT PROPERLY! IF NO. WEST DISCREPANCIES IN FIT AND GIVE REASONS THEREF 10 115 Z 21 INTEGRATED HANNESS TITTING WAS COMOUCTED BY FLISHT SURSEON PARACHUTE BIGGER AVIATION EQUIPMENT OFFICER OTHER 14 IF SHOULDER HARRISS WAS USED WAS IT THENT UNLOCKED OTHER COMDITION UNION OWN 26 LIST PRESCRIBED MODIFICATIONS Chin and mape strap; Hardeman fitting MET 17 OTHER MODIFICATIONS AND REASON FOR THEM 28. DID HELMET PIT PROPERLY! IF NO. GIVE BEASON *** N one TH HELMET FITTING WAS COMBUCTED BY PARACHUTE RIGGES AVIATION EQUIPMENT OFFICER OTHER TOPE CHUTE S! LAST PACKING DATE TE MODEL/TYPE BAILOUT DAYGEN 11 AUTOMATIC RIPCORD, IF INSTALLED (Model and type) HONE 27 March 1961 F-151300-5 Master Specialty 1000-0 See discussion of item H-6 AUTOMATICE 37, 36, 39, 40, & 11. 37 DIG CHUTE DEEN IMMEDIATELY! IF NO SIVE BEASON 38. ALTITUDE THAT CHUTE OPENED PERT DPENING SHOCK 40 BODY ATTITUDE AT OPENING 41 CORDITION OF CHUTE AFTER OPENING SEVERE 42 IF OSCILLATION WAS PRESENT, HOW WAS IT STOPPED! MODERATE BEVERE AS WEATHER CONDITIONS DUBING DESCENT (List in sequence) 45 TOPOGRAPHY OF LANDING SITE Bresion ditabes, rocky terrain, 48 WAS BAILOUT OFF BEFORE EXIT AFTER BRIT 49. GIVE DIFFICULTIES ENCOUNTERED WITH BALLOUT DETERM AND THEIF CAUSE, IF AN WHEN WAS IT ACTIVATED BEFORE EXIT WAS CHUTE HARRESS WAS A SITTING POSITION IN SLING OBTAINED DURING DESCENT! IF NOT: WHITE SNUG LOOSE 1 165 SEAT CUSMION IF PROVIDED [Model/Type] WAS PARABATT LANTAND CONNECTED TO LIFE VEST O RING! IF NOT. MITT -IF ATTEMPT WAS MADE TO RELEASE PARAMET SURING DESCENT, WAS RELEASE ACTIVATED SUCCESSIBILITY and shots Squadron lecture 725 IF 6 SUIT, EXPOSURE BUIT, FULL OR PRETIAL PRESSURE SUIT WAS WORK, DID IT FIT PROPERLY! IF NOT, LIST DISCREPANCIES IN FIT AND SIVE REASONS 123 DE WAS G BUIT EQUIPPED WITH A SPRING LOADED DISCONNECT ADAPTERT OF NO. GIVE REASON *** DO. LIST ALL ITEMS OF NOR-STANDARD CLOTHING OR EDSTINAL EQUIPMENT STILITED WAS ANY ITEM OF EQUIPMENT LOST! IF TES STATE ITEM, WHEN LOST, AN

SUPPLEMENT TO PAGE 4, SECTION G, VT-7 MOR 6-61 (SECKINGER, Neil Vincent)

0-60

LCDR SECKINGER's hard hat (APH-5) was lost, presumably, on his initial contact with the ground. Both chin strap and one Hardeman fitting were torn from the helmet (see enclosures 5-0 and 5P). It is believed that non-utilisation of the Hardeman suspension was responsible for the loss of LCDR SECKINGER's hard hat and, subsequently, for a portion of the severe and extensive craniocerebral traums sustained on impact with the ground.

£ 07 18	SECTIL A - E	ERGENCY EXIT					HOBEL N/C
(6)						1	723-1
1	S-SUSPECTED, E-ESTABLISHED				******		7
×	1. EJECTION - Attempted						1
×	2 - Accomplished	1					-
×	3 - Through canopy			J			
NO.	ERCTION DIFFICULTIES ENCOUNTERED	IF TES. EXPLAIR	PIFFICULTIES				
×	4 Prior to	7					
×	5 - During	7					
×	6 - Subsequent to	-					
	7 Give type and model of seat used	Sent Ass	embly, Pi	lot e	jestian 2	49-53009	-61
	8 BAILOUT - Attempted						
	- Accomplished						
LTITUDE	E AT TIME DE ESIT (free)			01 1/6			130-135 be
		Atte	mpred 200	-		1 11 11 11	
	ION OF A/C BITH 13 CONTROLLED?				T. D	I PLAPE	П. П.
-	POSITION AT ERIT OR IMPACT TO SEA ST	- ORENOWN	AIR TEMP. 20 W		ur Sowa	FULL	HATER 23. TIME IN A
			h :-		, sec		20. 11.00
000			•				_
L OUT				. FOR EM	PHEE!		
OR OLLI	Ejection E] =0	USE OF DIFFICULT		1		
110#	14 DIFFICULTIES WITH THIS EXIT WESE		DRE OF DIFFICULT				
ATER	DEACHING OPENING EXIT	6 '					
OR	DA BOOY POSITION BURING ESIT						
LIBT DI	THER FACTORS NOT INDICATED ABOVE WHICH AFFECTS	0 E1/1 FROM A/C					
			this accident.	Prep	are a detailed	narrative as	crount of the
			this accident.	Prep ch iten	are a detailed a discussed by	narrative acitem numbe	crount of the er (e.g., H30,
IVIVAL			i. Identify ea	ch iten	are a detailed by	narrative at item number	crount of the er (e.g., H30,
MUNIC	FACTORS. Check factors below which are factors checked below and att H31, etc.)		MAINTAINING	s soor 1	discussed by	narrative as	crount of the er (e.g., H30,
NUNIC	FACTORS. Check factors below which are factors checked below and att H31, etc.)		MAINTAINING	s sooy t	EMPERATURE:	narrative ac item numbe	crount of the er (e.g., H30,
WUNIC 30.	FACTORS. Check factors below which are factors checked below and att H31, etc.) CATIONS: C. Communicated position prior to mishap		MAINTAINING	ems use	EMPERATURE:	narrative acitem numbe	crount of the er (e.g., H30,
30. 31.	FACTORS. Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene		NAINTAININ	ems use	EMPERATURE:	narrative acitem numbe	crount of the er (e.g., H30,
30. 31. 32.	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices		NAINTAININ	ems use ems use ems use tre THER:	EMPERATURE: d as shelter d as clothing	narrative acitem numbe	crount of the er (e.g., H30,
30. 31. 32. 33.	FACTORS. Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices		MAINTAINING	ems use ems use ems use tre THER:	EMPERATURE: d as shelter d as clothing	item numbe	count of the er (e.g., H30,
30. 31. 32. 33.	FACTORS. Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices		MAINTAINING 50. 26 51. 16 52. P 53. O ENVIRONMEN 54. E	ems use ems use ems use tre THER: THER:	EMPERATURE: d as shelter d as clothing	item numbe	er (e.g., H30,
30. 31. 32. 33. 34. 35. VEL:	FACTORS. Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices		MAINTAINING 50. Pt 51. It 52. Pt 53. O ENVIRONDED 54. E 55. E	ems use ems use ems use tre THER: tral hal exposure	EMPERATURE: d as shelter d as clothing LARDS: to natural force	es nimais and pi	er (e.g., H30,
30. 31. 32. 33. 34. 35. VEL:	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIORS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices		MAINTAINING SO. IN SO. IN SI. III S2. Fr SX. O' ENVIRONBED S4. E S5. E S6. U	ems use ems use ems use tre THER: tral hal exposure	EMPERATURE: d as shelter d as clothing LANDS: to natural force to dangerous as	es nimais and pi	er (e.g., H30,
30. 31. 32. 33. 34. 35. VEL: 36.	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices OTHER: LAND		MAINTAINING SO. IN SO. IN SI. III S2. Fr SX. O' ENVIRONSE: S4. E S5. E S6. U S7. O' BORALE:	ems use ems use ems use ire THER: TAL HAI Exposure Exposure infriendi THER:	EMPERATURE: d as shelter d as clothing tamps: to natural force to dangerous as by mative popular	es nimais and pi	er (e.g., H30,
30. 31. 32. 33. 34. 35. VEL: 36. 37. LYER:	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices OTHER: LAND WATER		MAINTAINING SO. IN SO. IN SI. III S2. Fr SX. O' ENVIRONSE: S4. E S5. E S6. U S7. O' BORALE:	ems use ems use tire THER: xtal hai xposure afriend	EMPERATURE: d as shelter d as clothing tamps: to natural force to dangerous as by mative popular	es nimais and pi	er (e.g., H30,
30. 31. 32. 33. 34. 35. VEL: 36. 37. LYER:	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices OTHER: LAND		MAINTAINING SO. IN SO. IN SI. III SI. O' ENVIRONMEN S4. E S5. E S6. U S7. O' BORALE;	e sooy to sooy	EMPERATURE: d as shelter d as clothing tamps: to natural force to dangerous as by mative popular	es nimais and pi	er (e.g., H30,
30. 31. 32. 33. 34. 35. VEL: 38. 37. LYER:	FACTORS. Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices COTHER: LAND WATER Life raft Parachute A C structure		MAINTAINING 50. In 50. In 51. In 52. Pr 53. Or 6 6 6 6 6 6 6 6 6	s soor it seems use the seems	EMPERATURE: d as shelter d as clothing tamps: to natural force to dangerous as y mative popular	es nimais and pi	er (e.g., H30,
30. 31. 32. 33. 34. 35. VEL: 36. 37. LYER: 40.	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at some Electronic signal devices Visual signal devices Auditory signal devices OTHER: Life raft Parachute A.C structure Natural shelter		MAINTAINING 50. Re 51. It 52. Pr 53. O 63. E 54. E 55. E 56. U 57. O 50. ALE 50. P 60. L	s soor it seems use the seems	EMPERATURE: d as shelter d as clothing tamps: to natural force to dangerous as ly native popular gical shock	es nimais and pi	er (e.g., H30,
30. 31. 32. 33. 34. 35. VEL: 38. 37. LYER: 40. 41.	FACTORS. Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices OTHER: LAND WATER Life raft Parachute A/C structure Natural shelter Man-made shelter		MAINTAINING SO. Re SO. Re	s sooy to seems use the seems	EMPERATURE: d as shelter d as clothing tamps: to natural force to dangerous as ly native popular gical shock	es nimais and pi	igents
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30. 31. 32. 33. 34. 35. VEL: 38. 37. LYER: 40. 41.	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices OTHER: LAND WATER Life raft Parachute AC structure Natural shelter Man-made shelter OTHER:		MAINTAINING SO. Pe SO. Pe SI. 16 SI. 16 SI. 27 SI. 27 SI. 28 SI. 29 SI. 20 SI. 2	sooy to sooy t	EMPERATURE: d as shelter d as clothing tamps: to natural force to dangerous as y native popular gical shock notivation to sur	es nimais and pi	igents
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30. 31. 32. 33. 34. 35. VEL: 36. 40. 41. 42. 43. 72.8 SOI! 44.	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices OTHER: LAND WATER Life raft Parachute AC structure Natural shelter OTHER:		MAINTAINING SO. IN SO. I	E BODY I E BODY	EMPERATURE: d as shelter d as clothing tasps: to natural force to dangerous as y native popular gical shock notivation to sur	es nimais and pi	igents
30. 31. 32. 33. 34. 35. VEL: 36. 40. 41. 42. 43. 7ER SON	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIONS: . Communicated position prior to mishap . Witnesses at scene I. Electronic signal devices I. Visual signal devices I. Auditory signal devices I. LAND I. WATER I. Life raft I. Parachute I. A.C structure I. Natural shelter I. Man-made shelter I. OTHER: URCE I. Desalter kit, seawater or solar still		MAINTAINING SO. IN SO. I	E BOOY I E BOOY	EMPERATURE: d as shelter d as clothing tasps: to natural force to dangerous as y native popular gical shock notivation to sur	es nimais and pi	igents
30. 31. 32. 33. 34. 35. VEL: 36. 40. 41. 42. 43. 46.	FACTORS: Check factors below which are factors checked below and att H31, etc.) CATIONS: Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices Auditory signal devices WATER Life raft Parachute A/C structure Natural shelter Man-made shelter OTHER: URCE Desalter kit, seawater or solar still Rain, dew, snow, ice, etc.		MAINTAINING SO. IN SO. I	E BOOY I COME IN THE RESERVATION	EMPERATURE: d as shelter d as clothing tamps: to natural force to dangerous as y mative popular gical shock notivation to sur plants survival rations plants	es nimals and pi tion vive group coordi	igents

07 11	11	MERGENCY EXIT FROM A/C AND SURVIVAL FALLORS
	morvidus, (Lest, frut, middle)	
ECKL	NGER, Neil Vancent	124-1
E		Mann
×	1. EJECTION - Attempted	
x	2 - Accomplished	
X	3 - Through canopy	IF YES, ESPAIN DIFFICULTIES
5 80	***	THE LINEAR DIFFERENCE
X	4 Prior to	
X	5 - During	Con attended about
90000	5 - Subsequent to 7 Give type and model of seat used	Cont Assessed Billion
380	s samour - Attempted	Seat Assembly, pilot ejection 219-53009-61
-	- Accomplished	1
ALTITUD	DE AT TIME OF EXIT (feet)	10 ATTITUDE OR MANEUVER OF A/C AT EXIT OF IMPACT 11. AIRSPEED
	LEVEL SO ABOVE TOPOGRAPHY	Attempted Aborted Take-off 110-115 kts
COLLIS	SION OF A/C WITH 13 CONTROLLED?	14 POWER 15 WHEELS 16 PLAPS
64	HOUND WATER YES NO	UNABOWS ON OFF UP DOWN FULL UP PARTI
CANOPI	T POSITION AT EXIT OR IMPACT 18 SEA ST	ATE 19. AIR TEMP 20. WATER TEMP 21. A/C PLOATED 22. TIME IN MATER 23. TIME IN RA
0.00	CLOSED ZETTISONED	84 ·/ sec
IL OUT	7 24 ERIT USED 28 IS THIS THE P	ECONNENDED EXIT! IF NO STATE PEASON FOR CHOICE.
DR	Sjection k '	NO
SION	28 DIFFICULTIES WITH THIS ERIT WERE	27 STATE BATURE OF DIFFICULTY
#1TH	DEACHING OPENING EXITIN	•
OR	18. BOOT POSITION DURING EXIT	
ROUND	Normal for ejection	
RVIVAL	L FACTORS: Check factors below which are	appropriate for this accident. Prepare a detailed narrative account of the
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SUPPLEMENT TO PAGE 5, SECTION H, VT-7 NOR 6-61 (SECKINDER)

H-6

LCDR SECKINGER did not separate from his seat, and he came to rest, in the seat, 599 feet from the end of the rummay. CAPT (b) (6) realised that there was no rummay overrun and initiated ejection at the end of the rummay. Ejection control was in the front cockpit and, therefore, CAPT (b) (6) had ejection control for both pilots.

Ejection system.

- a. Rear seat 5/NH-407
 - (1) Neither face curtain initiator (T-30E1) fired.
 - (2) Neither face curtain cable cutter fired.
 - (3) Harness release gun was not fired.
 - (h) Neither the seat bottom bladder nor its initiator (T31E1) inflated or fired.
 - (5) Neither back bladder nor its initiator(T-31E1) inflated or fired.
 - (6) The "D" ring handle was pulled and the 2 (T-30E1) initiators were fired.
 - (7) The seat drogue gun was fired.
 - (8) The ameroid unit Arming pin was not pulled.
 - (9) Evidence strongly supports the fact that no pivot pin was in the striker bellcrank at the time of ejection. (See encl. 5M and 5M) Striker bellcrank engagement with the striker pin on the seat bulkhead produced sufficient rotation to pull firing pin from drogue gun, but the stroke was not sufficient to pull the ameroid aiming pin.

See Section E of this report.

25.	CTION 1 - PA	THOLOGICAL FAC	TORS (U	e A to det	note ANTE	MORTEM:	P for P	OST h	TEM, w	hen kno		applica	bir.i
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SUPPLEMENT TO PAGE 6, SECTION I, VT-7 MOR 6-61 (SECKINGER)

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CLINICAL RECOR	D	AUTOPSY PROTOCOL						
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Aircraft accident. This LCDE was taking off from South Field, NAAS, Kingsville, Tex. in a T2J-1, BUND 11,6222 when trouble developed and the aircraft crashed, with the pilot sustaining fatal injuries. Time of crash was 0900 on 25 May 1961.

CORONER'S CASE: R. J. Size, County Coroner Kleberg County 1217 West Richard Kingsville, Texas

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SECKINGER, Neil V., LCDR/USN,

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J-101094-DD

26 May 1961

GROSS DESCRIPTION

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SECKINGER, Neil V., LCDR/USN,



SECKINGER, Neil V., LCDR, USN, (b) (6)	J-101094-DD	NH32-25-jej 6120/1 61-25	
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HADIOGRAPHIC REPORT: SECRINGER, NEIL VINCENT, LCDR USN; (b) (6)
AGE 38; SEX HALE; BODY SERIES REQUESTED BY (b) (6)
FOLLOWING TRJ-1 CRASH (VT-7 HAAS KINGSVILLE, TEXAS)

KINGSVILLE FILES

BODY SERIES: (b)(6)

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RADI CORAPHIC REPORT: (b) (6)

AGE 31; SEX MALE; FOLLOWING T2J-1 CRASH (VT-7 MAAS KINGSVILLE, TEXAS) #2266-61 C-SPINE 5/25/61:

INH CC TEX

LT NC USN

Health and Sick Call Records are not considered pertinent to this accident.

Recommendations for Corrective Action

- 1. It is recommended that closer attention by supervisory authority be exercised both in adherance to Standard Operating procedures and in review of maintenance procedures. A continuous review of procedures by all personnel, flight and maintenance, must be examined periodically in an effort to remain cognizant of changes required or occurrences of non-compliance with standard operating procedures and/or check sheets.
- 2. It is recommended that both the intermediate and major check sheets on the maintenance of the ejection seats be revised so that the check sheet shows each item to be checked, especially the striker arm pivot pin, which is not listed on the check sheet. It is further recommended that no work be accomplished on the ejection system without a work order being issued.
- 3. It is recommended that only qualified personnel be permitted to sign off gripes on/or inspection of the ejection seat system. If the number of qualified personnel assigned do not meet the requirements of the command, then a strenuous, conscientious effort must be exerted to train enough other personnel to meet the needs. Special attention must be given to selecting only the most highly qualified personnel to be used as instructors.
 - h. It is believed that if CAPT (b) (b) had been wearing his oxygen mask at the time of his low level ejection, he would have died from suffocation. This belief is based on the figures of usable time/quantity of the bailout bottle, which is activated at ejection. The emergency oxygen supply is capable of providing approximately 2 to 3 minutes of normal breathing at sea level. From the time of initiation of ejection until help arrived for CAPT (b) (6) to 6 minutes had elapsed and CAPT (b) (6) was unconscious from the time he contacted the ground,

In view of the above it is recommended that the Bureau of Weapons immediately initiate a study of the problem, which is to insure that outside air be made available to the pilot as soon as the emergency oxygen supply has been depleted.

Summary and Conclusions

. . . .

No sociological, psychological, physiological, or pathological factors are judged to be operative in the genesis of this accident.

The primary contributing cause factor in this accident is the fact that the aircraft did not become airborne due to a suspected failure or malfunction of the elevator control system.

The contributing pilot cause factor in this accident is that a flaps up takeoff was attempted, which required almost the full length of the runway for takeoff rell and abort stopping distance. This same take-off attempt with flaps
down left 1500 feet of runway remaining after take-off rell and abort stopping
distance.

This take-off should never have been attempted for the following reasons:

- 1. Both pilots were Assistant Maintenance Officers and should have realized the significance of taking an aircraft that had discrepancies.
- 2. The low oil pressure would have been noted prior to commencing takeoff roll had the correct procedure of checking engine instruments been used.
 - The speed brakes not extended.

The procedure of going over check-off lists while taxiing on any type of flight is in violation of standard operating procedures of this squadron.



FOR 6-61 TRA I 7 TANS KINGS TILLE, TEXAS T2J-1 BING 118222, I PACT DA A E TO SAF TY TIL ST TWO TOURS TO THAT: (b) (6)



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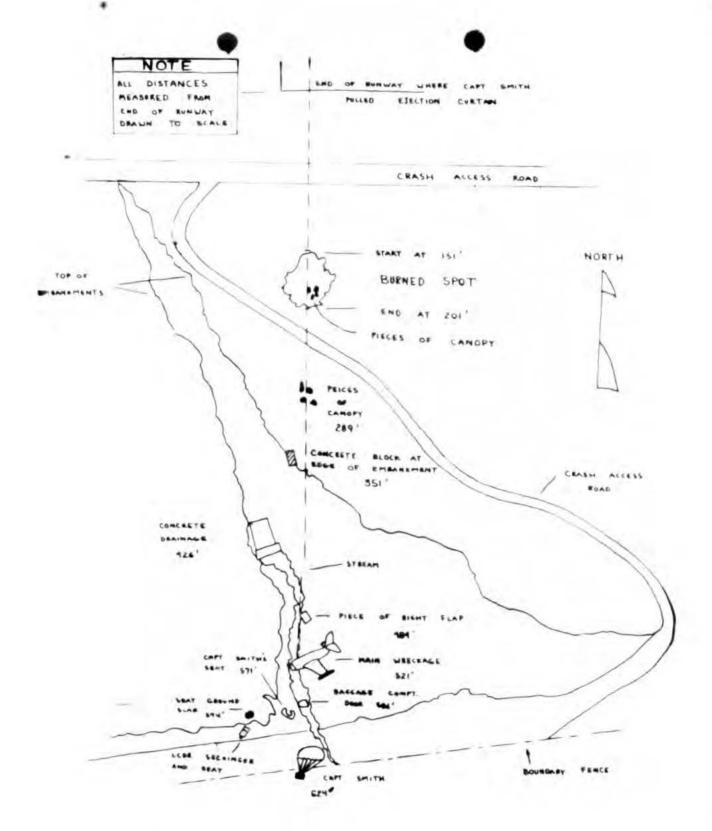


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MOR 6-61 TRANSH 7 HAAS KINGSVILLE, TEXAS. T2J-1 HUNO 118222. IMPACT DAMAGE TO SAFETY AND SURVIVAL EQUIPMENT. CO-PILOT: SECKINGER, M.V.

CHITISTING SA TRUNCS 7 AAR 6-61 T2J-1 BING 1A8222 FILAT: (1) ADSTRAFT PATH : LAGRAN FROM TAXI DEP STOT TO FILAGE MORE WRECKAGE CAME TO A STOR. DRAWTH IS TO SCALE. SPECIAL BANGLING REQUERED IN ACCORDANCE WITH PARAGRAPH 70 OPNAVIRST 3750.40.





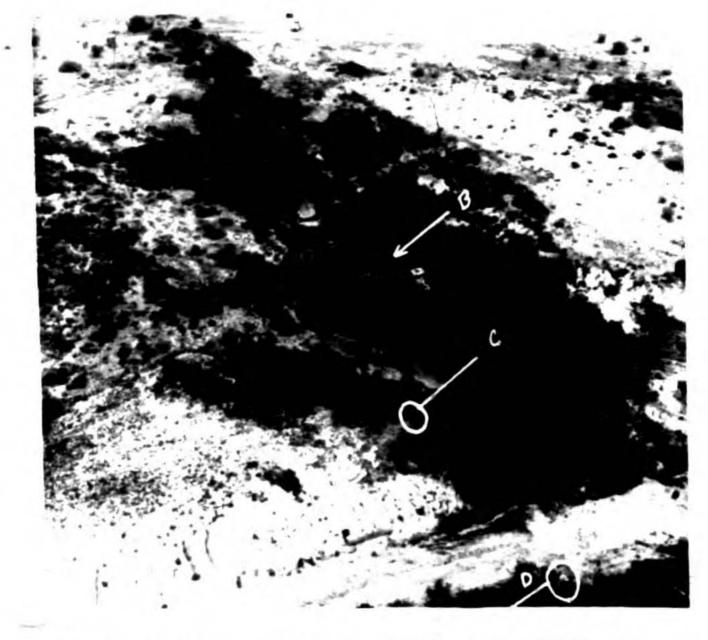
ENCLOSURE 68 THATON 7 AAR 6-61 12.1-1 BUND 118222. PILAT: (b) (6) VIEW OF WRENKAGE WHILE STANDING IN BOTTOM OF STREAM LOOKING TOWARD THE RUMAY. IT IS ESTIMATED THAT THE STREAM BED IS ABOUT 35 FEET BELOW RUNWAY LEVEL. SPECIAL HANDING REQUIRED IN ACCORDANCE WITH PARACRAPH 70 OPNAVINST 3750.6D.



ENCLOSURE 63 TRARON 7 AAR 6-61 T2J-1 BUN 1,8222. PILOT: (6) CLOSE-UP VIEW OF MAIN WRECKAGE SHOWING EXTENT OF BURN LAMAGE. THE RIGHT WING, DOCKRET AREA AND TOP OF FUSELACE WERE COMPLETELY CONSUMED BY THE ENSUING FIRE. STEEL LAD HANDLING REQUIRED IN ACCORDANCE WITH TARY FIRE 70 OPEN VINST 3750.60.



ENCLOSURE 6J TRARON 7 AAR 6-61 T2J-1 BUNO 148222 PILOT: (b) (6) VIEW OF BOTTOM OF CANOPY ACTUATOR SHOWING THE THREADS OF GAS TUBE FITTING ON ACTUATOR IN GOOD CONDITION. THIS INDICATES GAS TUBE WAS NOT CONNECTED TO THE FITTING WHEN ACCIDENT OCCURRED. SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 70 OPNAVINST 3750.6D.



CAPT. SMITH'S SEAT. (D) CAPT (b) (6)

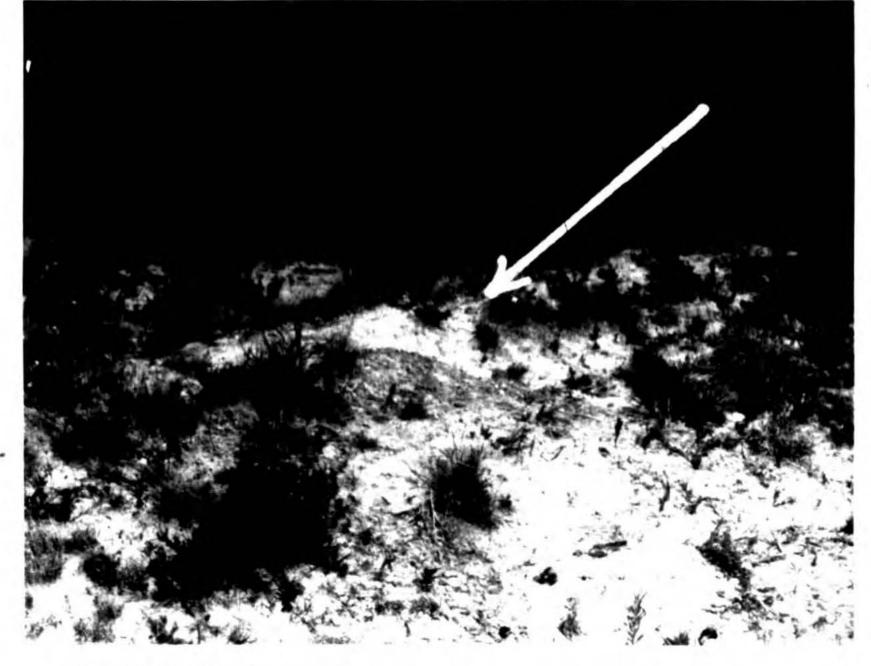
THROUGH THE TREES. (E) LCDR. SECKINGER AND SEAT. SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 70, OPNAVINST 3750.60.



ENCLOSURE 6D TRARON 7 AAR 6-61 T2J-1 BUNO 148222 FILOT: (6)(6) WHERE CAPT. (6)(6) SEAT CAME TO REST. SPECIAL HAMLING REQUEST IN ACCORDANCE WITH PARAGRAPH 70 OPWAYINGT 3750.6D.



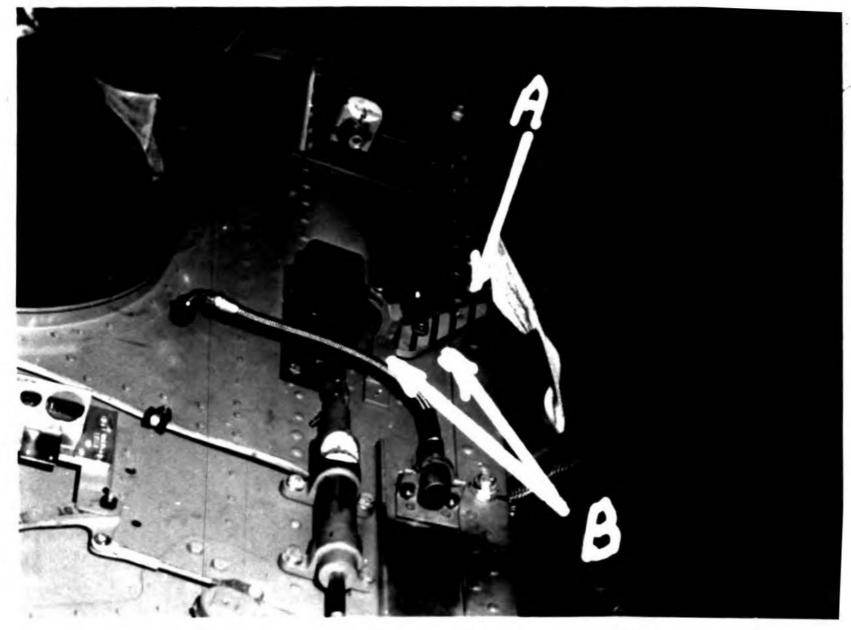
ENCLOSURE 6E TRARON 7 AAR 6-61 T2J-1 BUNG 148222. PILOT: (b) (6) . WHERE CAPT. (b) (6) PARACHUTE CANOPY LANDED. CAPT. (b) (6) WAS ON OTHER SIDE OF FENCE HAVING CONE THROUGH THE AREA INDICATED BY THE CIRCLE. CAPT. (b) (6) HIT THE TOP OF THE FENCE IN LOWER PART OF THE CIRCLE. SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARACRAPH 70, OPNAVINST 3750.6D.



ENCLOSURE 6F TRARON 7 AAR 6-61 T2J-1 BUNO 148222. PILOT: (b) (6) ARROW POINTS TO AREA WHERE LCDR. SECKINGER AND HIS SEAT CONTACTED THE GROUND. SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 70 OPNAVINST 3750,60.



ENCLOSURE 6G TRARON 7 AAR 6-61 T2J-1 BUNG 148222. PILOT: (b) (6) . WHERE LCDR. SECKINGER AND SEAT CAME TO REST. THIS WAS 25 FEET FROM WHERE CONTACT WITH THE GROUND WAS MADE. SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 70 OPNAVINST 3750.6D.



ENCLOSURE 61 THARON 7 AAR 6-61 T2J-1 BT: 1/8222 FILOT: (b) (6)

SHOWLING THAT THE ARM PIVOT CLEVIS AT ALL THE ACCORDANCE AITH AND ALLEGATE BY ENCLOSURE 61. (A) SHELLO AND (B)
WHERE PIN SHOULD BE. SPECIAL HANDLING REQUIRE IN ACCORDANCE AITH AND ALLEGATE TO OPNAVINST, 3750.60.



ENCLOSUPE 6H TRARON 7 AAR 6-61 T2J-1 BUNO 148222 PILOT: (b) (6)

OF LEFT SIDE OF LCDR. SECKINGER'S SEAT. THIS PHOTOGRAPH WAS TAKEN AT
THE SCENE BEFORE PILOT OR SEAT WERE MOVED. ARROW INDICATES POSITION OF
EJECTION SEAT STRIKER MECHANISM BELLCRANK. FOLLOWING PHOTOGRAPH (ENC. 61)
SHOWS COMPLETE BELLCRANK. SPECIAL HANDLING REQUIRES IN ACCORDANCE WITH
PARACRAPH 70 OPNAVINST 3750.6D.